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10 Attorneys for Plaintiff,
MELISSA KAY COOK Individually and
11 MELISSA KAY COOK as *Guardian ad*
Litem of Baby A, Baby B and Baby C

12 UNITED STATES DISTRICT COURT
13 CENTRAL DISTRICT OF CALIFORNIA
14 LOS ANGELES DIVISION

15 MELISSA KAY COOK Individually and
16 MELISSA KAY COOK as Guardian ad
Litem of Baby A, Baby B, and Baby C,

17 Plaintiffs,

18 vs.

19 EDMUND G. BROWN, JR., Governor of
20 the State of California, et al.,

21 Defendants.

Case No. 2:16-cv-00742 ODW(AFMx)

**DECLARATION OF MIRIAM
GROSSMAN, M.D. ON BEHALF OF
PLAINTIFFS, PURSUANT TO 28
U.S.C. § 1746**

(Fed. R. Evid. 201)

Date: May 23, 2016
Time: 1:30 p.m.
Courtroom: 11
Judge: Hon. Otis D. Wright, II
Trial Date: None Set
Action Filed: 2/2/16

1 MIRIAM GROSSMAN, M.D., being of full age, deposes and says:

2 1. I am a medical doctor licensed to practice medicine in the State of
3 New York. I am a Diplomat of the American Board of Psychiatry and Neurology
4 with a Specialty in Child and Adolescent Psychiatry and am a Diplomat of the
5 National Board of Medical Examiners.

6 2. I earned my undergraduate degree, cum laude, at Bryn Mawr College,
7 Bryn Mawr, Pennsylvania in 1974 and my Doctorate in Medicine from New York
8 University, New York, New York in 1979. I completed my internship in Pediatrics
9 at Beth Israel Hospital in New York City, New York in 1980 and completed my
10 residency in Adult Psychiatry at Cornell University's North Shore University
11 Hospital located in Manhasset, New York in between 1985 and 1987. Following
12 my residency, I remained at Cornell's North Shore University Hospital as a Fellow
13 in Child and Adolescent Psychiatry between 1987 and 1989.

14 3. During many of the years since I completed my education, I have been
15 in private practice in California and New York. I was licensed to practice medicine
16 in the State of New York in 1980, and in California in 1989. From 1995 through
17 2008, I practiced as a psychiatrist at the Student Psychological Services at UCLA
18 in Los Angeles, California, where, among other things I provided diagnostic and
19 emergency evaluations of undergraduate and graduate students, including students
20 in the Law, Medical and Dental schools. I was responsible for crisis intervention,
21 medical management, multi-disciplinary case management, teaching and
22 presentation to interns. During those years I worked with psychologists, social
23 workers and campus departments.

24 4. At U.C.L.A., I served on three different committees and reviewed
25 applicants for psychiatry positions and did peer reviews.

26 5. While most of my professional work has been clinical, I also taught at
27 the University of California San Diego Medical School and lectured at UCLA and
28 Southwood Hospital in San Diego, CA.

1 6. I have lectured widely to general audiences on a variety of topics
2 relating to child and adolescent mental and physical health.

3 7. I have read the Complaint filed in this case and am familiar with the
4 facts in this matter, including the facts recited therein.

5 8. All of my opinions expressed in this Declaration are within a
6 reasonable degree of medical certainty.

7 **Attachment, Brain Development, and the Mother infant Bond**

8 9. Experts in child development have long held that a child's earliest
9 emotional attachments will indelibly influence his developing personality and later
10 life experiences. According to attachment theory, the bond between a young child
11 and his primary caregiver will significantly impact his subsequent relationships,
12 including romantic choices, as well as his ability to navigate stress and adversity
13 (John Bowlby 1969).

14 10. An explosion of neuroscientific research has confirmed attachment
15 theory, and has demonstrated that a child's first bond is with his mother. (Leckman
16 J and March JS (2011) Editorial: *Developmental neuroscience comes of age*, Child
17 Psychology and Psychiatry 52:4 pp. 333-338; Schore A and McIntosh J (2011)
18 *Family Law and the Neuroscience of Attachment, Part 1* Family Court Review Vol
19 49:3 pp 501-512) This primordial attachment starts during pregnancy. The infant
20 recognizes, and is emotionally attached to, his mother, from before birth. He prefers
21 her scent and the sound of her voice and heartbeat. He craves her closeness,
22 especially at times of distress. She is his first care giver.

23 11. Pregnancy causes vast changes in the female brain that prime the
24 mother to care and nurture her child in a responsive and sensitive manner. (See, for
25 example: *Leng et al (2008) Oxytocin and the maternal brain* Current Opinion in
26 Pharmacology 8:731 734). In all but the most extreme adverse circumstances, the
27 mother is best suited to be the primary caregiver.

28

1 12. Attachment to the primary caregiver drives the infant's healthy brain
2 development. Evidence suggests that a critical period for the formation of brain
3 circuits vital to a child's emotional development is from the last trimester of
4 pregnancy into the second year. When attachment to caregivers is disrupted during
5 that time, it may alter the maturation of the brain, with serious, long reaching
6 consequences. Attachment experts are urging the legal profession to be aware of
7 these scientific advances in order to make informed legal decisions. (Schoore 2011).

8 13. Surrogacy – the planned, intentional removal of an infant from his
9 mother – deprives the child of his first primary caretaker. It represents a highly
10 significant loss during a most vulnerable and critical period of brain development..
11 To remove an infant from his primary caretaker by design is dangerous and should
12 not be allowed.

13 14. Melissa Cook is the mother of Baby A, Baby B and Baby C. She
14 therefore has a relationship with Baby A, Baby B, and Baby C as a matter of
15 biological fact. She became their primary caregiver at the moment the three
16 embryos were transferred into her uterus. The children's attachment with Melissa
17 was both biological and psychological, and it existed irrespective of intentionality
18 or genetic connection.

19 15. Researchers have reported that in reproductive related behaviors,
20 intentionality does not predict outcome. Even if a woman planned all along to give
21 up her child after birth, that intentionality cannot, in general, overcome or defeat the
22 powerful physiological and psychic processes of pregnancy that initiate distinct
23 maternal cognitions and behaviors. (Santelli J. et al, 2006 *An Exploration of the*
24 *Dimensions of Pregnancy Intentions Among Women Choosing to Terminate*
25 *Pregnancy or to Initiate Prenatal Care In New Orleans, Louisiana, American*
26 *Journal of Public Health* 96:11 p. 2009-2015)

27
28

1 16. Likewise, a written surrogacy contract, or any of the promises or
2 intentions expressed in it, cannot prevent the neurobiological bond between mother
3 and infant that naturally develops during pregnancy.

4 17. When C.M. demanded that Melissa Cook terminate the life of one of
5 her unborn children, that baby had no concrete reality for him. His relationship with
6 all the children, if he had any relationship at all, was abstract. In contrast, for
7 Melissa Cook, the children were every bit as real as she was. Indeed, they were a
8 part of her. She was the person responsible for their life, nurturing, health and
9 wellbeing.

10 18. It is difficult to overstate the essential and lifelong importance of the
11 mother/child bond. It is a unique relationship, irreplaceable, and the prototype upon
12 which all later attachments are based. Since mother and child are biologically
13 intertwined, their relationship is qualitatively distinct from any other relationship,
14 no matter how loving. The mother and infant are a unit, needing one another
15 physically and emotionally.

16 19. The child exists for the mother from the first signs of pregnancy, days
17 after conception. Her nausea, breast tenderness, and missed menstrual periods all
18 inform her that she is carrying a new human being. The woman focuses intensely
19 on these changes and what they represent. Her attention has shifted 180 degrees;
20 her life has forever changed. A bond with the child exists, whether planned or not,
21 whether welcomed or not. Later, the baby's first movement is a landmark event.
22 The mother focuses on her child, and wonders how does my baby move and how
23 often? Does my child move when I eat and when I'm trying to sleep? She begins to
24 ascribe to her baby a personality. Evidence of her child's presence intrudes on her
25 awareness as she goes through the day. By definition, he is more real for her than
26 for anyone else, because only she has this moment to moment awareness. Her
27 experience builds feelings that are powerful and protective.

28

1 20. The elevation of a pregnant woman's hormones, among them
2 oxytocin, prolactin, estrogen and progesterone, is dramatic, like no other time
3 during her life. Without exaggeration, it can be said that her system is awash in
4 hormones. As a result a woman's emotions and cognition during pregnancy may
5 differ decidedly from her pre pregnancy intent. Studies document the increases in
6 maternal feelings and attachment during pregnancy. Carter C & Fleming, A.S.
7 1990, *Maternal Responsiveness in Humans: Emotional, Cognitive and Biological*
8 *Factors*, *Advances in the Study of Behavior* 19: 83-36, New York: Academic

9 21. Oxytocin, a neuropeptide hormone, has been described as "the love and
10 bonding hormone;" it is critical for the development of effective parenting in
11 mammals. The secretion of oxytocin during pregnancy in women is similar to that
12 in other female primates and mammals. There is a link between oxytocin and
13 human mother child bonding. Feldman and colleagues (2007) published the first
14 empirical report on the topic, assessing oxytocin levels in sixty pregnant women
15 during the first and third trimesters and during the early post-partum period. The
16 study provided clear evidence of the biological basis for maternal psychological
17 responses to the fetus. Specifically, first trimester levels of oxytocin predicted
18 bonding related thoughts and bonding behavior directed to the newborn. Women
19 whose bodies were secreting more oxytocin early in the pregnancy were more
20 psychologically attached to their infants. Stronger attachment involved positive
21 energy directed towards the child, and maintenance of constant affectionate and
22 stimulating bodily contact with the child. Mothers who had high oxytocin levels
23 were also more preoccupied by thoughts of the infant, focusing on safety and the
24 infant's future. Feldman, R., Weller, A., Zagoory Sharon, O. Levine, A. (2007),
25 *Evidence for a Neuroendocrinological Foundation of Human Affiliation: Plasma*
26 *Oxytocin Levels Across Pregnancy and the Postpartum Period Predict Mother*
27
28

1 *Infant Bonding*, Psychological Science, 18:11, 965-970. Oxytocin is related to
2 mental as well as behavioral aspects of bonding.

3 22. Other studies have demonstrated that rising oxytocin levels during
4 pregnancy are associated with bonding process between a pregnant mother and her
5 child. Levine and colleagues (2007) demonstrated that oxytocin plays an important
6 role in the emergence of maternal responses. Levine, A., Zagoory Sharon, O.,
7 Feldman, R., Weller, A. (2007), *Oxytocin During Pregnancy and Early*
8 *Postpartum: Individual Patterns and Maternal Fetal Attachment*, Peptides, 28:
9 1162-1169.

10 23. Oxytocin is one of nature's primary means for insuring maternal
11 responses. The number of oxytocin receptors in the expectant mother's brain
12 multiplies dramatically in response to rising estrogen levels across pregnancy.
13 Surges in oxytocin levels occur during labor and as the infant travels through the
14 birth canal, oxytocin levels are elevated further in the mother. Through the birth
15 process the infant is imprinted on the mother and she experiences oxytocin related
16 feelings of calm and pain reduction. Carter, C. S., & Altemus, M. (1997),
17 *Integrative Functions of Lactational Hormones in Social Behavior and Stress*
18 *Management*, Annals of the New York Academy of Sciences, 807:164-174; Carter,
19 C. S. (1998), *Neuroendocrine Perspectives on Social Attachment and Love*,
20 *Psychoneuroendocrinology*, 23, 779-818; Uvnäs-Moberg, K. (1997), *Physiological*
21 *and Endocrine Effects of Social Contact: Integrative Functions of Lactational*
22 *Hormones in Social Behavior and Stress Management*, Annals of the New York
23 Academy of Sciences, 807, 146-163.; Uvnäs-Moberg, K. (1998), *Oxytocin May*
24 *Mediate the Benefits of Positive Social Interaction and Emotions*,
25 *Psychoneuroendocrinology*, 23, 819-835.

26 24. There are identifiable and specific neuroanatomical correlates of
27 maternal infant attachment. They can be seen in the post-partum brain and can be
28

1 striking. Noriuchi, Kikuchi & Senoo (2008) found there are certain areas of the
2 mother's brain that are specifically involved in the recognition of her infant,
3 namely, the orbitofrontal cortex, periaqueductal gray, anterior insula, and dorsal
4 and ventrolateral parts of the putamen. Noriuchi, M., Kikuchi, Y. & Senoo, A.
5 (2008), *Functional Neuroanatomy of Maternal Love: Mother's Response to Infant's*
6 *Attachment Behaviors*, *Biological Psychiatry*, 63:4, 415-423. The identification of
7 these highly elaborate neural mechanisms is yet another confirmation of the
8 strength and complex relationship between mother and child. See also: Kim,
9 Pilyoun (2010) *The Plasticity of Human Maternal Brain: Longitudinal Changes in*
10 *Brain Anatomy During the Early Postpartum Period*, *Behavioral Neuroscience*,
11 2010, Vol.124(5), pp.695-700; Kinsley, C. H. ; Amory - Meyer, E. (2011) *Why the*
12 *Maternal Brain?* *Journal of Neuroendocrinology*, Nov, 2011, Vol.23, p.974(10);
13 Kim, Pilyoung, Strathearn, Lane, Swain, James E. (2016), *The Maternal Brain and*
14 *its Plasticity in Humans*, *Hormones and Behavior*, January 2016, Vol.77, pp.113
15 23; Glynn, L (2010) *Giving Birth to a New Brain: Hormone Exposures of*
16 *Pregnancy Influence Human Memory*, *Psychoneuroendocrinology*, 2010,
17 Vol.35(8), pp.1148-1155.

18 25. Surrogate pregnancy is associated with ethical, legal, medical and
19 psychological dilemmas, many of which remain unresolved. Indeed, The American
20 Congress of Obstetricians and Gynecologists (ACOG) has issued an opinion stating
21 that surrogacy has "inherent" risks and presents serious ethical, legal and
22 psychiatric problems. ACOG, Committee on Ethics, Feb. 2008, No. 397. Due to
23 unanticipated and unexpected attachment issues largely unrealized or unaddressed
24 by the surrogate prior to becoming pregnant, surrogate mothers can face painful
25 separation trauma and anticipatory grief reactions as labor and delivery approach.
26 As a result, various sources recommend that surrogate pregnancy be treated as a
27
28

1 high risk psychological experience. Reame, N. (1991), *The Surrogate Mother as a*
2 *High Risk Obstetrical Patient*, Women's Health Issues, 1: 151-154;

3 26. For a gestational surrogate to undergo pregnancy through IVF, carry to
4 term, and relinquish her infant, she will need to exhibit a large degree of
5 dissociation from her feelings, to deny what her body informs her, and to detach
6 from her emotional investment in the child. Chesler, P. (1988), *Sacred Bond:*
7 *Motherhood Under Siege*, London: Virago. These are not simple or inherently
8 natural tasks even with pre selection psychological screening, extensive counseling
9 during pregnancy and after delivery/relinquishment, even when maintaining a
10 strong supportive network.

11 **Mothers Provide an Essential Benefit for Their Children**

12 27. The attempt to discount or devalue the role of pregnancy and the
13 relationship of mother and child during pregnancy is not only harmful to the
14 wellbeing of the mother, but is harmful to the child and it is harmful to society at
15 large. Detaching pregnancy and childbirth from motherhood denies the universal,
16 time honored truth that pregnancy and birth are the hallmarks, the very definition of
17 motherhood.

18 28. "Pregnancy is the beginning of a lifelong loving commitment to
19 parenting ...Pregnancy is and should remain a central and integral self-expressive
20 activity of loving and raising a child ..." New Jersey Bioethics Commission Report
21 on Surrogacy, (1992), *After Baby M: The Legal, Ethical and Social Dimensions of*
22 *Surrogacy*, " pp. 99-101.

23 **Mothers Provide an Essential Benefit for their Children**

24 29. There are extensive differences between males and females in the
25 ability to interpret nonverbal communications and to empathically resonate with
26 emotional states. Neuroscience indicates that pre and postnatally, the mother's right
27 brain (the instinctive, emotional part of her brain that is sensitive to the infant's
28

1 needs and non-verbal communication) is key to her role as primary caregiver.
2 (Shore AN (2005) *Back to basics: Attachment, affect regulation, and the*
3 *developing right brain: Linking developmental neuroscience to pediatrics.*
4 *Pediatrics in Review*, 26, 204-212. Mothers provide a unique and essential
5 benefit for the children they carry, give birth to, and raise. Attachment security in
6 children has been found to be associated specifically with maternal sensitivity,
7 responsiveness to distress, and appropriate stimulation. Consistent research
8 findings demonstrate the importance of an early, secure attachment for the
9 development of emotional regulation including regulating one's own emotional
10 arousal as well as more complex executive capacities. Attachment security has also
11 been found to contribute to early conscience development. Cole, P.M., Martin, S.E.
12 & Dennis, T.A. (2004), *Emotion Regulation as a Scientific Construct:*
13 *Methodological Challenges and Directions for Child Development Research*, *Child*
14 *Development*, 75, 317-333; Schore, A.N. (2001), *Effects of a Secure Attachment*
15 *Relationship on Right Brain Development, Affect Regulation, and Infant Mental*
16 *Health*, *Infant Mental Health Journal*, 22, 7-66; Sroufe, L.A. (1996), *Emotional*
17 *Development: The Organization of Emotional Life in the Early Years*, New York;
18 Cambridge University Press; Laible, D.J. & Thompson, R.A. (2000), *Mother-Child*
19 *Discourse, Attachment Security, Shared Positive Affect, Early Conscience*
20 *Development*, *Child Development*, 71 (5), 1424-1440. Children who were
21 insecurely attached to their mothers demonstrated poor self-regulation in toddler
22 and preschool years, while those with secure attachments developed self-regulation.
23 Kochanska, G., Philibert, R.A. & Barry, R.A. (2009), *Interplay of Genes and Early*
24 *Mother-Child Relationship in the Development of Self-Regulation from Toddler to*
25 *Preschool Age*, *Journal of Child Psychology and Psychiatry*, doi: 10.1111/j.1469
26 7610.2008.02050.x.

27

28

1 30. Consistent and repetitive interactions between mothers and children
2 facilitate children’s trust in their care givers, builds healthy social relations, and
3 provides intellectual stimulation. Attachment theory emphasizes the need for
4 consistent care over a period of time as the growing relationship between mother
5 and child forms the critical foundation for the development of future secure
6 relationships. Belsky, J. (2001), *Developmental Risk (Still) Associated with Early*
7 *Child Care*, Journal of Child Psychology and Psychiatry, 42, 845-860; Long
8 periods of separation may disrupt this process and “even short periods of mother-
9 child separation, up to 30 hours a week, may reduce the stimuli that is necessary for
10 children’s intellectual development.”

11 31. Infants need secure bonds of attachment to thrive. There is no
12 relationship that can approximate the natural, biologically based bond between
13 mother and child that develops as a result of pregnancy, birth, nursing, and early
14 interactions.

15 32. Odors are a significant part of an infant’s life, and through them the
16 infant/mother bond continues to strengthen. At birth, smell is the most
17 developmentally advanced of all the senses. Sullivan, R 2000 *Review: Olfaction in*
18 *the Human Infant*, available at www.researchgate.net/publication/242084746. A
19 newborn recognizes his mother’s – and only his mother’s – scent, and is soothed by
20 it. During pregnancy, women develop a distinctive pattern of five volatile
21 compounds that are released in the nipple and underarm areas. These chemicals
22 pass into the amniotic fluid and the fetus is exposed to them from early in
23 pregnancy, when the sense of taste begins to develop. After birth, the infant is
24 attracted to, and soothed by, the mother’s unique scent. It is partially because of this
25 scent, that he can locate her nipple and be nourished. (Vaglio S et al 2009, *Volitale*
26 *signals During Pregnancy: A Possible Chemical Basis for Mother-Infant*
27 *Recognition*, Journal of Chemecology 35:131-139.)
28

1 33. Women, particularly women of reproductive age, have a more acute
2 sense of smell in comparison to men. (Oliveira-Pinto AV et al, 2014 *Sexual*
3 *Dimorphism in the Human Olfactory Bulb: Females Have More Nuerons and Glial*
4 *Cells Than Males* PLOS ONE 9 (11): e111733.) Studies have found that 90% of
5 mothers could recognize their baby's smell after only 10 to 60 minutes of exposure
6 to their infant. (Kaitz, M et al., 1987 *Mothers Learn to Recognize the Smell of*
7 *Their Own Infant Within Two Days*, Developmental Psycho Biology: 120(6): 587-
8 91; Weisfeld, GE et al., 2003 *Possible Olfation Based Mechanisms in Human Kin*
9 *Recognition and Inbreeding Avoidance*, Journal of Experimental Child Psychology
10 85:3 p279-295.) Flavors from the mother's diet during pregnancy are transmitted
11 to amniotic fluid and swallowed by the fetus. Consequently, the foods and drinks
12 consumed by women during pregnancy impact the child's later food preferences.
13 The child prefers the tastes of foods that are familiar to him from before birth, that
14 is, the foods his mother ate during pregnancy (Mennella JA 2001, *Prenatal and*
15 *Postnatal Flavor Learning by Human Infants*, Pediatrics 107(6):e88.)

16 34. The fetus is surrounded by a rich auditory environment: the sounds of
17 his mother's heart, breathing, gastro-intestinal system, and voice. The mother's
18 voice is the most salient sound for the fetus, rising above other sounds by as much
19 as 24 decibels. The fetal ear is well-equipped to hear, and is able to recognize his
20 mother's voice in five seconds. He prefers not only his mother's voice, but its
21 prosody. He prefers his mother's native language (Voegtline KM et al 2013 *Near-*
22 *Term Fetal Response to Maternal Spoken Voice*, Infant Behavior and Development,
23 36, 526-533; Guellai B et al, 2015 *Suprasegmental Information Affects Processing*
24 *of Talking Faces at Birth*, Infant Behavior and Development 38 11-19 Krueger C et
25 *al 2014 Emergence and Retention of Learning in Early Fetal Development*, Infant
26 Behavior and Development 37,162-173.)

27 35. When a mother is nursing, her milk is customized nutrition as well as
28 protection against infection. There are a great many unique benefits to breast milk,

1 long and short term, including immune maturation and organ development. Human
2 milk changes in composition according to the needs of the infant, compared to
3 formula which is standardized within a very narrow range of composition.

4 Mother's milk provides the infant with the ideal nutrition. No other milk is so well
5 matched to the infant's needs. Exclusive breast feeding for the first six months,
6 with continued breast feeding for 1 to 2 years or longer, is recognized as the
7 normative standard for infant feeding. (Ballard 2013 *Human Milk Composition:
8 Nutrients and Bioactive Factors*, Pediatric Clinics North America, 60 (1) 49-74.)

9 36. It is my understanding that in this case, the defendant and his lawyers
10 refused to use M.C.'s breast milk, which contains all of the benefits described
11 above, to feed the three newborn boys, although she offered to provide it for them.
12 Instead, they sought out donated breast milk from other women.

13 37. Oxytocin is contained in mother's milk and is also released via
14 cuddling. It promotes a baby's attachment, relaxation, trust. At the same time,
15 infant hand motions and sucking cause increase of maternal oxytocin (Matthiesen,
16 *AS et al 2001 Postpartum Maternal Oxytocin Release by Newborns: Affects of
17 Infant Hand Massage and Sucking*, Birth Vol 28, (1) 13-19.) A mother's breast
18 warms up according to needs of infant (thermal synchrony). (Ludington-Hoe SM *et
19 al 2006 Breast-Infant Temperature With Twins During Shared Kangaroo Care*,
20 *Journal Obstet Gynecol NeoNatal Nurs* 35 (2): 223-231.)

21 38. Sensitive parenting by the mother during infancy favorably impacts
22 social outcomes across childhood and into adulthood. These outcomes include
23 diminished psychopathology, social adaptation, empathy, emotion regulation, and
24 creative-symbolic thinking. Bowlby J. 1969 *Attachment and Loss*, Basic Books;
25 Feldman R 2010 *The Relational Basis of Adolescent Adjustment: Trajectory of
26 Mother Child Interactive Behaviors From Infancy to Adolescence Shape
27 Adolescence's Adaptation*, *Attach Hum Dev* 12 173-192
28

1 39. It has been found that mothers consistently invested more time than
2 father figures, and with lower levels of variation between individual mothers and
3 mothers were more heavily involved in child care, especially for young children.

4 40. Absentee motherhood is non-normative. Absentee fatherhood is
5 highly prevalent. Of 19 million children living with one parent, at least 88% live
6 with their mother and 12% with their father. Even in those circumstances where
7 children experience their parents' divorce, the involvement of mother and fathers in
8 the lives of their children is vital. Research confirms that it is optimum for children
9 to have the benefit of both parents in their upbringing. (Living Arrangements of
10 Children (2004), Current Population Reports, Table 1, pp. 70-114. Washington,
11 D.C.: US Census Bureau)

12 **Unique Contributions of Mothers to Their Children's Self-Esteem and**
13 **Psychological Development**

14 41. In a longitudinal study of the relationship between mothering and
15 children's mental health, it was found that children whose mothers provided more
16 empathy, consistency, affection, and management of aggression during infancy had
17 higher levels of coping skills as adults than children who received less effective
18 nurturing.

19 42. It is my understanding that M.C. has challenged how the statute
20 impacts her but has also brought a facial challenge of the statute. In that light, I
21 wish to proffer a few comments about the mother-child relationship vis a vi
22 daughters as well as sons. The mother child relationship is uniquely essential for
23 daughters. Mothers were identified by girls as more influential than the media,
24 internet, television, and celebrities in terms of the girls' estimations of beauty.
25 Maternal influence was found to be particularly related to girls' satisfaction with
26 their appearance and to their self-esteem. For young girls, self-image and feelings
27 concerning physical appearance directly affect attitudes and behaviors. Findings
28 have revealed that dissatisfaction with physical appearance may prevent women

1 from attending social events, sharing their opinions, or pursue an education or
2 career.

3 43. Mothers have a unique capability to help their daughters face the
4 difficult and demanding world of their peers and of their culture with strength and
5 confidence rather than shame and doubt. While that does not apply directly to the
6 facts in this case, this fact does have relevance to surrogacy as implemented under
7 the California statute. By comparison, the researchers concluded that boys in
8 general (10%), fathers (7%), or romantic partners (15%) played a far lesser role in
9 shaping these attitudes. When daughters perceive their relationships with their
10 mothers to be loving and accepting, their self-esteem and role satisfaction are
11 significantly enhanced.

12 44. This special relationship between mother and daughter also has
13 important implications for the psychosexual development of girls. For example,
14 reported that adolescent girls feel freer to talk about sex and birth control with their
15 mothers than with any other single person. Also, mothers who communicate with
16 their daughters about sexual risk impact their daughters' behavior in positive ways.
17 (Hutchinson, M.K., Jemmot, J.B., Jemmot, L.S., Braverman, P. & Fong, G.T.
18 (2003), *The Role of Mother-Daughter Sexual Risk Communication in Reducing*
19 *Sexual Risk Behaviors among Urban Adolescent Females: A Prospective Study*,
20 *Journal of Adolescent Health*, 33(2), 98-107.)

21 45. There are also unique contributions to parenting that only mothers can
22 provide particularly in the areas of psychosexual development, self-image and self-
23 esteem and sexual attitudes (Jaccard, J., Dodge, T. & Dittus, P. (2003), *Maternal*
24 *Discussions About Pregnancy and Adolescents, Attitudes Toward Pregnancy*,
25 *Journal of Adolescent Health*, 33(2), 84 87). The power of the positive influence of
26 healthy mother-child relationships is apparent in its persistence into adulthood.
27 This influence is evidenced in enhanced self-esteem and role satisfaction (and more
28 effective interpersonal interactions in adulthood.

EXHIBIT 1

Curriculum Vitae

Contact Information

Name: **Miriam Grossman, M.D.**

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Email: MiriamGrossmanMD@hotmail.com

Phone: 845-406-3750

Education

1970-1974 Undergraduate: Bryn Mawr College, Bryn Mawr, Penna.
B.A., *cum laude*

1975-1979 Medical School: New York University, New York, NY

1979-1980 Internship: PGY I, Pediatrics, Beth Israel Hospital, NYC

1985-1987 Residency: PGY II and III, Adult Psychiatry
North Shore University Hospital (Cornell
University)
Manhasset, New York

1987-1989 Fellowship: Child and Adolescent Psychiatry
North Shore University Hospital (Cornell
University)

Employment and Affiliations

Present position. Private Practice, Suffern, New York

February 09 - April 2011 Vista del Mar outpatient clinic. Los Angeles, CA.

- 1995- 2008 UCLA Student Psychological Services, Los Angeles, CA
Evaluation and psychopharmacological treatment of students
Provided diagnostic and emergency evaluations of undergraduate
and graduate students including international students and those at
the law, medical, and dental schools. This represents a very
complex and diverse population. Crisis intervention and
hospitalization, medication management, multidisciplinary case
management, teaching and presentations to interns, consultation to
staff consisting of psychologists and social workers, consultation
to other campus departments as needed. Consulted with
the Office of Student Disabilities, and the UCLA School of Law.
- 2000-2005 Private psychiatric practice. Diagnostic and emergency
evaluation of children, adolescents and adults. Crisis
intervention, medication management and psychotherapy.
- 2000-2001 Psychiatrist, Vista del Mar outpatient clinic. Evaluation and
medication management of children and adolescents;
consultant, Julia Ann Singer Center - Therapeutic School for
Emotionally Disturbed and Developmentally Delayed
Children.
- 1994-1995 Psychiatrist, Inpatient Adolescent Unit, Talbia Mental Health
Center, Jerusalem, Israel.
- 1991-1993 Consultant, Young Adolescent Program, Southwood Hospital,
Chula Vista, CA., including inpatient privileges.
- 1991-1994. Staff Psychiatrist, Frontier Adolescent Day Treatment Center,
Santee, CA
- 1989-1993 Private Practice with Psychiatric Centers at San Diego,
CA. Provided general child, adolescent and adult psychiatry,
both inpatient and outpatient, emergency and diagnostic

evaluations, crisis intervention, medication management, case management, consultation to multidisciplinary staff.

1992. Clinical Investigator, Feighner Research Institute, San Diego, CA.
- 1989–1994 Inpatient privileges at Alvarado Parkway Institute, San Diego, CA.
- 1987-1989 Psychiatric residency at Cornell University affiliated North Shore University Hospital, Manhasset, NY in child and adolescent psychiatry. Consultant to the emergency room and to the pediatric and adolescent medical floors. The center specialized in the treatment of abused children and their families, eating disorders, and suicidal adolescents.
- 1985-1987 Psychiatric residency at Cornell University affiliated North Shore University Hospital, Manhasset, NY in adult psychiatry. Consultant in the emergency room, admitted to the inpatient unit, and cared for hospitalized and clinic patients. Consulted to medical and surgical floors as well as ICU's. Diagnostic interviews, crisis intervention, medication management, ECT.
- 1974-1975 Research assistant for Peter Auld MD, Director, Neonatology Department, Cornell University Medical Center. Examined sleep and respiratory patterns of premature infants and how these patterns may be related to sudden infant death syndrome.
- Summer 1971 EEG lab assistant (electroencephalography), Presbyterian University Hospital, Department of Neurology, Pittsburgh, Pennsylvania. Prepared patients for exam, applied electrodes to head, monitored patient during exam, studied basic principles of electrical activity of the brain, and assisted attending neurologist in library research.

Teaching:

- 1997 UCLA Student Health Center: "Psychiatric Emergencies"

- 1993 Instructor, University of California at San Diego Medical School
"Human Growth and Development"
- 1992-1993 Presented lecture series at Southwood Hospital, San Diego, CA
Topics included Tourette Syndrome, sexual abuse of children,
child and adolescent psychopharmacology

University Committees:

- 2006 Member, UCLA Selection Committee-Psychological Services to
review applications and interview applicants for psychiatry positions.
- 2005-2006 Member, UCLA Student Psychological Services Peer Review
Committee. Attend weekly meeting in which difficult and
complex cases are reviewed and treatment recommendations
made.
- 1995 Member, system-wide committee of the University of California
charged with developing practices for the documentation and
accommodation of students with ADD/ADHD

Awards

- 2003 UCLA Physician's Performance-Based Augmentation Award
(PPBA)
- 2000 UCLA PPBA award
- 1999 UCLA PPBA award
- 1974 Jane V. Myers Scholarship

Licensure

- 1980 Diplomat, National Board of Medical Examiners
- 1989 California License G067174

1991	Diplomat, American Board of Psychiatry and Neurology
1993	Diplomat, Specialty of Child and Adolescent Psychiatry
2012	New York License 144915-1

References available upon request.