JEAN MERCER

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

THE CLERK:	You do solemnly affirm the testimony you shall give in the cause now pending before this court will be the truth, the whole truth and nothing but the truth.
	A: Yes, I do.
	Please state your first and last name and spell it for the record.
	A: Jean J-e-a-n Mercer M-e-r-c-e-r.
	Thank you. Mr. Myers, you have the floor.
	MR. MYERS: Thank you, Your Honor. Your Honor, could I ask clerk if we might have the exhibit binder for minor's counsel handed to the witness? We will do so.

DIRECT EXAMINATION

By: JOHN E.B. MYERS, Attorney at Law, counsel on behalf of the Minors:

	Good morning, Doctor. I'd like to begin by asking you some questions about your background so that the court can determine whether you qualify to testify as an expert in this area so I would ask you to begin by describing for the court your educational background?
	A: I have a Bachelor's degree in psychology from Occidental College and a Ph.D. in general experimental psychology from Brandeis University.

	Dr. Childress Comment: She is not a clinical psychologist. She has never trained to be a clinical psychologist. She has never received any coursework or any training in the procedures involved in assessment, diagnosis, and treatment generally, nor with any pathology. Nothing, zero, she has no knowledge about nor training in the assessment, diagnosis, and treatment of any pathology. She has never assessed, diagnosed, or treated anything, and she has never been educated or trained to do so. **Dr Childress Comment:** In the State of California, the term "psychologist" is called a "protected term," meaning that certain qualifications are necessary to call yourself a psychologist. The requirement is that the person be licensed by the State of California. To be licensed you must be a clinical psychologist. By California State law Section, California Business and Professions Code BPC § 2903 (a) No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter.
	Q: And describe for the court without going into all the details since you had a long career your work experience, your professional work experience?
	A: I was at various levels a professor of psychology 1968 on up until my retirement in 2006.
	Dr. Childress Comment: She hasn't been involved in any aspect of professional psychology for over ten years.
	Q: And what was the university that you retired from?
	A: Stockton University in New Jersey.
	Q: Now, some of us in California don't know about Stockton University, is that a private school, a state
	A: No. It's one of the state colleges.
	Dr. Childress Comment: She has a degree in experimental general-ed psychology, she taught general-ed psychology courses at a small college in New Jersey, she retired from teaching 10 years ago. This is not an expert in anything. Ten years ago, she was a psychology course instructor at a small college in New Jersey teaching general education psychology courses.
	Q: All right. And what was your position at Stockton University?
	A: I was professor of psychology there?

	Q: All right. And were you a tenure professor?
	A: Yes, I was.
	Q: Now, do you still have a merit?
	A: Yes. I'm professor of psychology.
	Q: And so since 1968 you've been basically in the academic world?
	A: That's right.
	Q: All right. And can you briefly describe some of the courses that you've taught that would be relevant to why we're here today?
	A: Yes. I taught child development. I taught developmental psychology which is a slightly different course. I taught research methods. I taught statistics. I taught experimental psychology. I taught sensation and perception and I taught cognitive psychology.
	Dr. Childress Comment: Nothing about the assessment, diagnosis, or treatment of pathology. She was a general-education psychology teacher at a small college… over ten years ago.
	Q: Okay. Thank you. Now, have you published any professional works?
	A: Yes.
	Q: Have you published any books?
	A: Yes, I have.
	Q: Any books that would be relevant to let's say attachment?
	A: Yes. Two of those, one is called understanding attachment right here.
	Dr. Childress Question: Where did you receive your training in the attachment system and attachment pathology? A: She has none.
	Q: And when was that book published?
	A: This was published in 2006.
	Q: And can you briefly describe without going into detail what that book is, it's about attachment obviously, but is it a general discussion for students about attachment?
	A: It's what they call a trade textbook that exists in general discussion. It's for students, but it's also for educated lay people who are interested in the topic.

	Dr. Childress Comment: She has no background or training in attachment, she has no background or training in clinical psychology (the assessment, diagnosis, and treatment of pathology), she wrote a book over ten years ago on the topic of attachment. She's not an expert in anything. "It's for students," she says. She has no students. She retired in 2006, over a decade ago. She has no students. "It's a trade textbook," she says, but she hasn't taught anything in over a decade. She's not an expert in anything.
	Q: And I take it you have been interested in the subject of attachment for some time?
	A: Yes, I have.
	Dr. Childress Comment: She has a hobby. That's nice. That is not a professional expertise. She has never assessed, diagnosed, or treated any pathology – and she has never received any training to do so.
	Q: All right. Over your career have you studied attachment?
	Dr. Childress Comment: She may have read books about it, to call that "studied attachment" overstates her involvement. She has never conducted any research on attachment, and she has never assessed, diagnosed, or treated any attachment-related pathology. The minor's counsel is misleading the court – not directly, but by inference. She has not studied" attachment, she's read books on attachment perhaps.
	A: Yes. I am studying attachment actually back in the early days of attachment theory began. When John Bowlby was beginning to write some of the things in the'70's and '80's particularly.
	Q: We'll come back to that in a bit now. So you published books, have you published articles that deal with attachment?
	A: Yes, I have.
	Q: Are your books and your articles contained in your curriculum vitae?
	A: Yes.
	Q: We'll get to that in a moment. So have you ever in your professional capacity presented at professional conferences regarding attachment?
	A: Yes, I have.
	Q: Can you give us an estimate of how often that would have occurred?

	A: Probably 10 or 15 times all together. The most recent presentations I made were to various mental health associations. In the last couple of months I presented on the relationship between attachment issues and the separation of migrant children.
	Q: That's a very interesting subject in itself. Are you a member of any professional organizations?
	A: Yes.
	Q: Can you tell the court what organizations you belong to?
	A: The American Psychological Association.
	Q: How long have you been belonged to the APA?
	A: Twenty years I suppose and I belong to two divisions, the clinical child psychology division; although, I'm not a clinician and the child youth and family division.
	Dr. Childress Comment: She belongs to the clinical child psychology division – but she's not a clinical psychologist. Never has been a clinical psychologist. Why is she a member of the clinical psychology division? She's a wannabe clinical psychologist… A clinical psychologist in her own mind – except she lacks all of the knowledge and training.
	Q: Do you belong to another professional society?
	A: Yes. The society for research and child development.
	Q: Now, I suppose all of us in the courtroom although we're not psychologists have heard of the American Psychological Association, but some of us may not have heard of the society for research and child development. Can you tell the court a little bit about that society?
	Dr. Childress Comment: Sending in an enrollment postcard and membership dues does not confer any knowledge or expertise. Minor's counsel is trying to hide the absence of expertise behind a veil of associations. She has never assessed, diagnosed, or treated any pathology, and she has neither the education nor training to do so. She is not an expert in anything. She's a 10-year retired teacher of general education psychology courses at a small college in New Jersey. Now, she just has time on her hands, and she likes that someone is interested in her opinions and acts like she has valuable knowledge.
	A: Yes. It's an organization which publishes a very respected journal which is called Child Development and the concern is with all aspects of child development from infancy through adolescence and this includes a wide number of issues including social and emotional

	development, perceptional development, cognitive development and also family issues like parenting.
	Q: Now, are you a peer reviewer for peer review psychology and social work journals?
	A: Yes, I have been.
	Q: I'm sure the court is familiar with peer review, but can you briefly put on the record what your function is for peer review for these journals?
	A: Okay. When a draft of a journal article is submitted to the journal the editor then takes that draft and removes all identifying materials and they will know who the author was and sends it out to selected people who serve as reviewers, these are people who presumably, you know, know something about topic and are published on it themselves. You then take, the peer reviewer takes the article and comments on it making recommendations about accepting or rejecting it or most often accepting it with revisions and make suggestions about revisions that would strengthen the article.
	Q: And have you been a peer reviewer for a number of years?
	A: Yes, I have.
	Q: And within your areas of expertise as a professional of psychology, would you consider attachment to be one of the areas of your expertise?
	Dr. Childress Questions: Where did you receive your training in attachment? (nowhere). How many cases of attachment-related pathology have you assessed? (none). How may cases of attachment-related pathology have to diagnosed? (none). How many cases of attachment-related pathology have you ever treated? (none). Have you ever conducted any research on the attachment system? (no). So what, exactly, makes you an "expert" in attachment besides your own self-assertion?
	A: Yes.
	Q: Have you been qualified to testify as an expert witness in other courts?
	A: Yes, I have.
	Dr. Childress Comment: It speaks to the sorry state of our response from professional psychology to the legal system's need for professional guidance, that this person is considered an "expert" in anything. She may well be a very nice old woman with lovely views about things, that she thinks are really important, but she is not an expert in anything.
	Q: Do you remember how many times that has occurred just roughly?

	A: Okay. Three times.
	Q: And was one of those in California?
	A: Yes.
	Q: What county was that in?
	A: Santa Barbara.
	Q: You know, at this time, Your Honor, I tender Dr. Mercer as an expert on attachment and child development and I suppose before I do that I better ask one more question since I have something, let me ask you this, Doctor, before I ask whether the court is going to rule on you as an expert, do you have expertise in an interest of what we might call unorthodox psychotherapies?
	A: Yes. That's been one of my most serious interest in the last 20 years.
	Q: Can you help us understand what you mean by unorthodox therapies?
	Dr. Childress Comment: Do you mean like UFO conspiracy sort of "serious interest"? With all due respect, Dr. Mercer, you don't even know standard therapies. In fact, you know nothing about psychotherapy – you're not a clinical psychologist. I understand you may WANT to be a clinical psychologist, but you are NOT a clinical psychologist – no training, no education, no background. You don't even know normal-range therapy. You have a "serious interest," that's sweet. I'm glad you're concerned. You're not a clinical psychologist, you don't know anything about therapy. Nothing about it.
	A: Yes. There are treatments which are provided for people of all ages, but I'm especially interested in those for children which are essentially intentions of the therapists which do not have a basis in empirical evidence which is often implausible and in some cases are actually harmful to the individual.
	Dr. Childress Comment: You know nothing about therapy. Nothing. No education, no training, you've never done any, you know nothing at all about psychotherapy. So what is the basis for your judgements about psychotherapy? You know nothing – zero – about any form of psychotherapy. You are not a clinical psychologist – no training, no education, no experience. Nothing. And yet, you are offering us your "expert" opinion on psychotherapies.
	Q: Did you write a book about such therapy?

	A: Yes, I did.
	Q: Do you remember when that book was published?
	A: That's a good question. 2014 I think it was.
	Q: So now, Your Honor, at this time I would tender Dr. Mercer to the court as an expert on attachment, child development and unorthodox therapies.

Dr. Childress Comment: That's a problem. Under California State law, a person can only testify as an expert in psychology and matters related to psychology… if they are licensed in the State of California – meaning a licensed clinical psychologist.

Relevant California Statutes

California Business and Professions Code BPC § 2902

(c) A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychology consultation," "psychology consultant," "psychometry," "psychometrics" or "psychometrist," "psychotherapy," "psychotherapist," "psychoanalysis," or "psychoanalyst," or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology.

California Business and Professions Code BPC § 2903

(a) No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.

Dr. Childress Comment: In offering Dr. Mercer, who is NOT licensed and would never qualify for licensure, to the court as an "expert on attachment, child development and unorthodox therapies," minor's counsel and Dr. Mercer are in violation of California Business and Professions Code § 2903.

I am not an attorney. I am a clinical psychologist. From where I sit, it appears to be a conspiracy to present fraudulent "expert" testimony to the court in order to mislead and deceive the court regarding the credibility of alternative

professional testimony given by a clinical psychologist licensed by the state of California.

I would consider an administrative review by the California State Bar Association of the professional legal practices of the minor's counsel would be warranted. Fraudulent "expert" testimony was submitted to the court in violation of California state law, BPC § 2903.

"No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter." BPC § 2903

"A person represents himself or herself to be a psychologist when… the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology. BPC § 2902

	THE COURT: Any desire to voir dire?
	MR. POSNER: No, Your Honor.
	MS. MOJADDIDI: No, Your Honor, that's fine.

Dr. Childress Comment: In my opinion, this decision by legal counsel was in serious error. There were avenues to explore in voir dire.

	THE COURT: Great. I will allow Dr. Mercer to so testify.

Dr. Childress Comment: Ms. Mercer is now in violation of California state law BPC § 2903.

If she testifies on any area of clinical psychology – the assessment, diagnosis, and treatment of any pathology – then she will be in violation of Standard 2.01a of the APA ethics code:

2.01 Boundaries of Competence
(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.

	MR. MYERS: Thank you, Your Honor, and at this time I would offer her curriculum vitae which is marked as minor's 209 into evidence as minor's 209.
	THE COURT: Any objections?
	MR. POSNER: No objection.
	MS. MOJADDIDI: No, Your Honor, I don't think that the witness was asked to review it, but I'm assuming it is the most current one that she would say.

	THE COURT: That's a fair point.
	MS. MOJADDIDI: Yeah.
	THE COURT: Dr. Mercer, do you have the exhibit binder?
	THE WITNESS: Yes, I do.
	THE COURT: Will you please look at tab 209.
	A: Yes.
	THE COURT: Does that appear to be your current curriculum vitae?
	A: Let me just check the last page.
	THE COURT: Okay.
	A: The only thing that's missing here is the two presentations last month that I had mentioned.
	THE COURT: 209 will be admitted.
	MR. MYERS: Thank you Your Honor.
	MR. MYERS: Your Honor, may I ask the witness would it be useful to have a water. Oh, you got it with you.
	A: Yeah.
	Q: Never mind.
	A: If nobody minds if I drink it.
	Q: Is it okay if she takes it?
	THE COURT: She may.
	MR. MYERS: Okay. Then at this time I would begin substantive questioning by asking you, Doctor, in general terms if you can help us understand what is attachment theory? May I start by talking about what attachment
	Dr. Childress Comment: This is where minor's counsel begins to construct the false narrative in collaboration with Dr. Mercer which will be offered to the judge. It is a false narrative. Minor's counsel seems to have an obsessive fixation with disorganized attachment, I'm not sure why (although I suspect it would be something

counter-transference). He will be constructing some odd construction of reality in which I'm proposing all sorts of things.

I'm not. What he and Dr. Mercer say I say is not true. What she says we do in diagnosis, is not true. It is a fabric of falsehoods. This is the beginning of its construction. Minor's counsel will spend a lot of time asking a lot of entirely irrelevant questions about disorganized attachment, essentially using Dr. Mercer to read passages from articles into the record.

What is introduced into evidence through this process is pretty much entirely irrelevant.

A: Sure. Defining attachment is not nearly as easy as people usually think it is. If you look at most textbooks you're going to see definitions such as any emotional tie or any emotional bond between two people, but it turns out when you examine that kind of definition more carefully these are actually metaphors which are rather confusing. Attachment does not actually mean that two people have exactly the same feelings about each other, and therefore, to talk about it as a tie or a bond is probably deceptive. I prefer to talk about attachment as a social preference for proximity to specific other people. That social preference is most likely to be expressed in times of stress, the way the social preference is expressed changes with maceration and development so the way that young children show their social preference for familiar adults is really quite different from what we would see with older children, with adolescence or with adults, but in any case, what we're talking about here is not so much a tie as an attitude on the part of one person that they prefer to have the company of a specific one or small number of other people and they may avoid separation from those people under many circumstances and they may feel very uneasy when approached by unfamiliar people. This, of course, changes with age.

Dr. Childress Comment: Defining the attachment system is actually pretty simple. The attachment system is a primary motivational system of the brain that promotes parent-child bonding. It developed over millions of years of evolution involving the selective predation of children. The attachment system is the brain system that governs all aspects of love and bonding throughout the lifespan, including grief and loss.

Mary Ainsworth provides the following definition of attachment:

Ainsworth, M.D.S. (1989). Attachments Beyond Infancy. American Psychologist, 44, 709-716.

"I define an "affectional bond" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711)

"An "attachment" is an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (p. 711)

Dr. Mercer: "to talk about it as a tie or a bond is probably deceptive"

Mary Ainsworth: "An "attachment" is an affectional bond"

Dr. Childress Comment: Dr. Mercer is not an expert in anything, and already, right from the start, she is giving **false** information to the court.

	Q: Is there a term in the attachment literature called the attachment system?
	A: Yes, there is
	Q: Can you help us understand what that term means if it is meaningful?
	A: Okay. To do that I better talk about attachment theory.

Dr. Childress Comment: To be clear, attachment theory is just as much a "theory" as the theory of gravity. Is gravity a theory? Yes, I suppose. Is gravity real. Yes, very much so.

Pretty much everything in science is a theory. Quantum theory in physics. The theory of evolution.

There is a large and substantial research base to the attachment system. We know what it is, we know how it functions, we know how it dysfunctions.

	Q: Sure.
	A: Okay. All right. Any kind of theory is going to be essentially a framework that someone has created to try to pull together things that they can observe in the world so when we have a theory of attachment we're looking at behaviors which we refer to as attachment behaviors and we're talking about what it might be behind the scenes or inside the person that we can assume to be pulling together these behaviors causing them explaining them, linking them with other kinds of behavior. One of the ways that attachment theories have talked about what's behind attachment behavior is that there is essentially some kind of internal system which regulates this. Now, in order to talk about this in a meaningful way you really have to talk about some of the behaviors that we see in young children and why anybody would be willing to say is there a system behind this or not.

Dr. Childress Comment: Her opening sentences were vague and did not convey an understanding for the attachment system. Her last sentences about needing to understand the behaviors of the child is starting to ramble and is not accurate.

	A: Typically, what we see in children of toddler age is going to be that they have two different ways or two different extremes of ways that they behave in the world. One is that they try to stay close to familiar people, the other is that they go out and explore.
	Dr. Childress Comment: She's referencing Margaret Mahler's work on individuation from the 1930s, Bowlby accepted this work from Mahler.
	A: Now, when I say go out and explore I don't mean if they were in this room they would leave, but they might walk around here and look at different things. Now, what we have here is a child who does things which are apparently to some extent contradictory, sometimes they want to stay close, sometimes they want to go away.
	Dr. Childress Comment: She's missing the fundamental point of the attachment system – the reason to stay close is predators. Predators target and eat children. If children don't remain close to their parents, they are eaten by predators. That's the evolutionary pressure creating a neurological primary motivational system of the brain – the attachment system. From Bowlby: "The function of attachment behavior is protection from predators. (Bowlby, 1969, p. 227) From Bowlby: "The biological function of this behavior is postulated to be protection, especially protection from predators. (Bowlby, 1979. p. 3) Children remain close to the parent for protection from predators. When they feel safe (secure) that a parent is watching out for them, then they will venture away from the parent in exploratory behavior, such as play or tasks.
	A: What can we use as a term for whatever is going on inside the child that determines which way they go a hypothetical construct called a system so in the early days of attachment theory this was developed as an idea about how attachment operates that there is an attachment control system which helps to determine whether they stay close to their familiar people, there's an exploratory control system which helps to control whether they go out and explore and learn about the world. The interesting thing about this is that although there's been decades of discussion of the attachment control system hardly anybody ever talks about the exploratory control system so, in fact, people don't anymore really spend a lot of time talking about these things as coordinating systems but that was the original idea.
	Dr. Childress Comment: She's completely rambling nonsensically at this point, talking about some sort of "control system" and "hypothetical construct" – this information is not true. The attachment system is a neurologically embedded primary motivational system. It's organized in the right pre-frontal orbital cortex (Siegel, Cozolino, Stern, Shore). It is also strongly influences by the mirror neuron networks of the brain (the intersubjectivity system; Tronick, Stern). It's not a "hypothetical

construct" – it's a neurological network – a primary motivation system – that has been amply demonstrated in the research literature.

She's just making stuff up, what she's saying is not true. That's what happens when you allow someone who doesn't know what they're talking about to start explaining things – they get it wrong.

She's also talking about it being some sort of control system. It's not. That's not true. It is a motivational system. It motivates behavior, it doesn't "control" behavior. Control systems are more in the frontal lobe executive function networks and in language systems.

The attachment system is a motivational system that promotes affectional bonding between the child and parent. Listen to how Mary Ainsworth defines it… it's not a "control system":

Ainsworth, M.D.S. (1989). Attachments Beyond Infancy. American Psychologist, 44, 709-716.

"I define an "affectional bond" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711)

"An "attachment" is an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (p. 711)

	Q: Okay. Is the theoretical idea?
	A: Yes, it is.

Dr. Childress Comment: No, it's not. It is a neurological network in the brain – a primary motivational system that evolved across millions of years of evolution. What Jean Mercer is testifying to is false information. She is providing the court with false information because she doesn't know what she's talking about.

Minor's counsel is presenting false testimony to the court, in violation of California state law on expert testimony by psychologists (she's not a psychologist by California state law, she is not licensed). What she is saying is not true.

	Q: So I suppose we can't talk about attachment without mentioning the name John Bowlby, can we?
	A: It would be difficult.
	Q: And who was John Bowlby?
	A: John Bowlby was a British psychiatrist and psychoanalyst who in the late '30's and early 1940 began to think about some of the issues about early social and emotional development and attempted to formulate some ideas of what are the steps in early social and emotional development and what determines how those steps go. Now, Bowlby was looking at observations of things that people have known about for thousands of years, it's nothing brand new in what Bowlby observed. What was new was his attempt to create a theory, in other words, a framework in which he could pull together the observations that he made so the things that he observed were,
	Dr. Childress Comment: There are fragments of truth and reality, John Bowlby was a British psychiatrist and psychoanalyst, but pretty much everything else is false. People hadn't known about a primary motivational system in the brain for motivating parent-child bonding for "thousands of years" – that's not true – and he did open doors onto something "brand new" – and it's as much a theory as the theory of gravity. She is ignorant. Completely and entirely ignorant, and she's simply making things up. She knows nothing about the attachment system (I suspect she's not bright enough to comprehend what's discussed, so she fills in the gaps in her understanding with make-believe stuff she makes up).
	A: for example, a toddler and I'm saying here a child between maybe 10 months of age and 2 and a half or 3 years of age, that child will under a number of circumstances want to stay close to familiar people. That child will under certain circumstances avoid or been afraid of strange people or strange places. That child will be able to use a familiar person as what's called a secure base, that is if we bring the toddler into this room along with a familiar person first the child's going to stay close to that familiar person, then the child's going to start going out and looking at different things, maybe looking at different people, then look back to the familiar person, maybe go back, maybe actually touch them, go out again and so on. And that's through a base behavior one of the things that seems to make it possible for toddlers to handle this big scary world and get out there and learn things about it. The one more observation that, you know, had been known along time that Bowlby made a big point of including this in his theory is the fact that when a toddler has developed this kind of attitude or behavior toward a familiar person and that toddler is abruptly separated from that familiar person, the toddler will often protests loudly about this, sometimes not just protest loudly but if the separation goes on a long time becomes depressed, withdrawn, and shows essentially grief for the loss of the person so these were the observations that Bowlby was working with. Now, he tried to figure out how to put this together in a meaningful way. Do you want me to go on talking about how he put it together.

	Q: Are we to Mary Ainsworth yet?
	A: She's a little bit down the road.
	Q: Let's go to Mary.
	A: Okay. Go to Mary Ainsworth. Mary Ainsworth was a Canadian psychologist who following in World War II went to London and became interested in Bowlby's work and essentially volunteered to work with him and she was interested in figuring out how it would be possible, not just to do kind of general observations, but the kind I've been talking about but whether you could systematically develop a way in which you could look at toddlers attachment behavior, attachment and separation behavior and so she developed a method which is still used, it's called a strange situation and in this she was able to essentially code how a child's behavior in a separation situation could be assessed and how you would assign that child to one of several categories of quality of attachment. And I do want to point out that although people often talk about strong attachments, weak attachments and so on, none of that actually belong to attachment theory. What belongs to attachment theory is the idea that there's a particular type of attachment behavior which is shown so you categorize the child as showing one or another type of that behavior.
	Dr. Childress Comment: Mind you, none of this is relevant to the matter under consideration. It is a long way to nowhere.
	Q: Now, you mentioned the strange situation?
	A: Yes.
	Q: Ainsworth created as a research tool; is that correct?
	A: That's right.
	Q: Is it a clinical tool?
	Dr. Childress Comment: She is being asked to render an opinion of clinical psychology. I have used variants of the Strange Situation in my work with children as the Clinical Director for a children's treatment center for children in the foster care system. We don't need precise categories, but a loose clinical variant of the Strange Situation will place us in the ballpark of attachment classification issues. Dr. Mercer is not a clinical psychologist, it is beyond the scope of her expertise to render an opinion on matters of clinical psychology. If she answers this question by rendering an opinion, offered to the court, regarding the practice of clinical psychology she is practicing beyond the boundaries of her competence, a violation of Standard 2.01a of the APA ethics code.
	A: No.

	Dr. Childress Comment: She is now in violation of both California state law BPC §2903 and Standard 2.01a of the APA ethics code.
	Q: When you say it's not a clinical tool, what do you mean by that?
	A: What I mean by that is that it would not be a valid proceeding to take an individual child to test them in a strange situation and then to say on the basis of what this child has done I now can diagnose a particular problem and/or I can recommend a treatment that should be done. This is something which applies to groups of children, it does not apply to individuals in the same way.
	Dr. Childress Comment: That is a false statement from the perspective of clinical psychology. She is providing the court with false information from clinical psychology. She has never assessed, diagnosed or treated ANY pathology – she has never assessed, diagnosed, or treated attachment pathology. What she is saying is not true, she is giving false information to the court because she is practicing beyond the boundaries of her education, training, and professional experience in rendering opinions on the practice of clinical psychology.
	Q: Could you briefly describe for the court what the strange situation is?
	A: Okay. In the strange situation what we have is a physical setup which involves a sort of little waiting room, a room that has several doors that can be opened and closed and you know an outside hall, some toys in the room so I'm going to say mother here because it is usually the mother whose involved in this particular kind of testing. The mother and child come into the room and, again, we're talking about a child, this was originally applied 12 to 20 months. Nowadays people usually say up to 2 and a half, 3 years work, the mother and the child go into the room, there are toys there, over the first couple of minutes the mother sees, you know, if the child doesn't go straight to the toys she sees if she can get the child interested, there's a stranger sitting in the room too who's doing some observation. After a couple of minutes when the child is playing with the toys the mother gets up and leaves the room. She's away for just a couple of minutes, if by the way if the child really gets upset of her going you stop, you know, this is not away to get little kids all upset.
	Dr. Childress Comment: That's not true about the child becoming upset. The Strange Situation is designed to upset children – to stress their attachment system – they are stressed and distressed when mother leaves the room. The procedure is done with a 2-way mirror room (which is what typically limits its clinical application, the lack of a 2-way mirror office and professional expertise in the Strange Situation). The procedure is monitored from behind the 2-way mirror, and the "stranger" in the room is a mental health professional or aide, so there is no danger or damage to the child from a brief separation. The feature we want to look at is

	the quality of the reunion. We stress the attachment system and see how it responds.
	A: She goes out, then in a couple of minutes she comes back into the room. Now here's the point that is really of interest and this is how you assess their attachment quality with the strange situation. What happens when the mother comes back, it's the reunion between the mother and the child, that's the important thing here so in, you know, maybe 60 percent of cases the child will have been a little bit upset, now rushes over to the mother, maybe she picks him up but very quickly they're comfort, they go back to playing. When that's the case they're said to show secure attachment and by the way, there's no match up about secure attachment, this is just a category that's used. In other kinds of circumstances the child will not be as easy to comfort, the child may snub the mother, you know, she approaches, they temporarily won't look at her, in other cases, the child's will go up to the mother as if coming to be comforted but then resist. It's a kind of a snub, too, but it's an angrier kind of snub. Now, in a small number of cases and I'm jumping past Ainsworth here because this was not Ainsworth's idea, but this is what people do nowadays, the child will be behave in a very peculiar manner and they do lots of different things but they're all really quite unusual so when the child sees the mother come back into the room he may just fall to the floor flat or he may walk toward the mother while covering his face or maybe even back up to the mother. At the same time the mother is looking frightened. The mother looks distressed or blank or, you know, she isn't just feeling concern with the child. When we see that kind of behavior which is pretty unusual it's referred to as disorganized attachment and in disorganized attachment when you're essentially seeing is a sequence of contradictory behaviors so the child approaches but looks away or approaches but pushes the mother, you know, does something to her, backs up to the mother, and this is considered to be the most concerning attachment category that the child can be in. Those insecure attachment categories, you know, this sounds alarming which you're not supposed to be insecure but in fact this is a very minor issue for those kids.
	Dr. Childress Comment: No, it's not a "minor issue" for those kids. None of this is relevant to post-divorce family conflict with adolescents.
	Q: So the strange situation, is this a laboratory procedure that's done at universities?
	A: Yes, usually.
	Q: Is this a procedure that's done in your typical child psychologist office?
	A: No.
	Q: Are very many American children subjected to the strange experience, strange situation?
	Dr. Childress Comment: None of this is relevant to post-divorce family conflict with adolescent children.
	A: No.

	Q: Is it a tiny percentage of American children?
	A: Actually, I have no idea how many but this is a research paradigm.
	Q: So it's not part of normal mental health practice?
	A: No.
	Q: All right. Is the strange situation by Dr. Ainsworth the only scientifically valid and reliable way to assess attachment?
	A: Well, it's referred to as the gold standard whether that means it's really the only possible way, I really couldn't say. There are a number of other possible approaches that can be taken. There's one that is done actually in the child's home. There are several that are used for slightly older children. There really is nothing that's for children more than 6 years old up until you get to adults where there are sort of questionnaire approaches that are used for assessing attachment but for school age and adolescence, no, there really is nothing.
	Q: So you briefly mentioned, but I just want you to summarize for us, the four types of attachments that have been observed by psychologists.
	A: Okay. Well, keep in mind this is a textbook description, these are categories and so you have to put the child in these categories, right, so no doubt somebody could have designed something where there are 60 different categories but they haven't done so. Normally when what people talk about is the secure attachment in 2 types of insecure attachments, one is avoid aunt and one is resistant and then the disorganized attachment.
	Dr. Childress Comment: That is a bizarre comment about somebody coming up with "60 different categories" of attachment – no, that's not possible. She obviously doesn't understand the attachment system. She's just making stuff up. She, and minor's counsel, are providing the court with false information.
	Q: What is the most common type of attachment
	A: Secure.
	Q: And do you know what roughly what percentage American children receive that label?
	A: That label, it's about 60 percent.
	Q: And do you know about what percentage of American children who go through the strange situation would be characterized as disorganized attachment?
	Dr. Childress Comment: This continues as entirely irrelevant to a post-divorce family conflict with adolescent children.
	A: Well, that depends entirely on the group that you're looking at. If you just took the population out of, you know, every nursery school in Sacramento or something like that you

	probably wouldn't have as many as 5 percent but if you take a high risk population maybe 15 percent.
	Q: Okay. That's very helpful. Thank you doctor. We'll come back to attachment but I want to shift gears for a minute and ask you are you familiar with the Diagnostic and Statistical Manual of mental disorders published by the American psychiatric association?
	A Yes.
	Dr. Childress Comment: Dr. Mercer is not a clinical psychologist, she has never been trained in diagnosis and the DSM-5. If she renders an opinion about diagnosis and the DSM-5 she is practicing beyond the boundaries of her competence, in violation of Standard 2.01a of the APA ethics code.
	Q: And I know you testified that you're not a clinical psychologist, but are you familiar in your teaching and your work with the clinical process of diagnosis?
	Q: Yes
	Dr. Childress Comment: She has never been trained in the DSM-5, in the process of diagnosis, or in clinical psychology. It doesn't matter what she may be "familiar" with, she is not allowed by Standard 2.01a to render a professional opinion outside the boundaries of her competence. **2.01 Boundaries of Competence** (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.
	MS. MOJADDIDI: I'm sorry, Your Honor, can I just ask that the question right before this one, I just didn't catch the full question, it went really fast.
	THE COURT: Do you have that there, Mr. Myers?
	MR. MYERS: Oh, are you familiar with the DSM-5?
	MS. MOJADDIDI: Okay. Got it.
	Dr. Childress Comment: Counsel should probably have objected to the scope of the question being beyond what the "expert" was qualified for in testimony. The court qualified her in child development, attachment, and unusual therapies, NOT in the DSM=5, diagnosis, or the procedures and methods of clinical psychology – she has no education, training, or background in the assessment, diagnosis, or treatment of any pathology.
	MR. MYERS Q: Are you familiar with the DSM-5 if we can use that abbreviation?

	A: Yes, I am.
	Q: Now, realizing that you're not yourself a clinical psychologist but are a psychologist who is familiar with the process of diagnosis, can you briefly

Dr. Childress Comment: This question is fraught with peril for Dr. Mercer. She is not a psychologist. Under California state law, you cannot call yourself a psychologist unless you are licensed – meaning a licensed CLINICAL psychologist. Someone with a PhD in experimental psychology is not licensed – is not qualified to be licensed – and is NOT a psychologist.

If Dr. Mercer accepts the designation of herself as a "psychologist" then she and minor's counsel are perpetrating fraud on the court regarding her qualifications as allowed and designated by California State Law.

"No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter." BPC § 2903

"A person represents himself or herself to be a psychologist when… the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology. BPC § 2902

Dr. Childress Comment: She may be "familiar with" the DSM-5 – she has NO training, education, or background in diagnostic procedures or pathologies. If she renders an opinion on the diagnostic procedures surrounding the DSD-5, she is practicing beyond the boundaries of her competence in violation of Standard 2.01a of the APA ethics code.

2.01 Boundaries of Competence
(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.

	Q: …describe for the court what is the process by which a mental health professional reaches the conclusion that a person has a diagnosis of mental illness as defined in in the DSM-5?

Dr. Childress Comment: She is being asked to render an opinion beyond her boundaries of competence – she has never been trained in diagnosis of pathology, she has zero education and zero professional background in diagnosing pathology. She should not answer this question.

2.01 Boundaries of Competence
(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.

A: Well, the first step would ordinarily be to take a history because for differential diagnosis, trying to decide which range of diagnoses is appropriate. It's often going to be the case that you're looking for etiology. What is the possible cause of a particular kind of problem so that would be the beginning and then, of course --

Dr. Childress Comment: Dr. Mercer is in violation of Standard 2.01a of the APA ethics code. She is not a clinical psychologist, she should not render an opinion on diagnostic procedures used in clinical psychology.

2.01 Boundaries of Competence
(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.

What's more… she is wrong. She is 100% wrong when she says, "Its' often going to be the case that your looking for etiology." That is a false statement. Diagnosis is anchored in symptom features and symptom patterns – NOT etiology.

Dr. Mercer is acting beyond the boundaries of her competence, she is misrepresenting herself to the court in violation of California state law BPC § 2903, and she is fraudulently giving the court false information about the procedures of professional diagnosis.

Dr. Childress Comment: This is also the pivot point where minor's counsel and Dr. Mercer begin to construct an alternate reality – an alternate truth – regarding diagnosis.

From this point on, they will adopt an etiology-based assumption regarding diagnosis. This is 100% incorrect. Diagnosis is based on symptom features and symptom patterns. Etiology is not a diagnostic factor. It may be a treatment-related factor, it is not a diagnostic factor. Their co-construction of a false description of diagnostic procedures is then used to create a straw-man argument relative to my writing in Foundations. Diagnoses are symptom-based, NOT etiology-based.

Q: I'm sorry to interrupt you, Doctor, but when you say take a history, what does that mean?

Dr. Childress Comment: She has never taking a history and symptoms in her entire life. She has never been trained in taking a history and symptoms. She has no information on which to base her answer. If she answers this question,

	she is practicing beyond the boundaries of her competence. She is not a clinical psychologist. **2.01 Boundaries of Competence** (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.
	A: You're going to -- well, let me take an example of looking at a child where you're going to be asking what kind of disorder is present. There are going to be a number of things you would want to know about them, what were the circumstances of the birth, are they still with the same caregivers that they were born to, have there been medical problems, have there been previous behavior problems, if that's what you're looking at now, is it a kid who got kicked out of, you know, story hour at the library regularly. All of those issues are going to be significant for diagnosis.
	Dr. Childress Comment: Dr. Mercer is AGAIN, practicing beyond the boundaries of her competence – and AGAIN is giving 100% false information to the court. That is NOT how a history and symptoms interview is conducted. What Jean Mercer is saying about the collection of history and symptoms relative to diagnosis is false. **2.01 Boundaries of Competence** (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. Minor's counsel and Jean Mercer are conspiring to present false information to the court. She is not a clinical psychologist, she has NO training in the assessment, diagnosis, and treatment of anything. The information she is providing to the court at the questioning of minor's counsel is false. The court is being misled.
	Q: And are you familiar with the diagnosis of borderline personality disorder?
	A: Yes.
	Dr. Childress Comment: The domain of pathology, such as borderline personality disorder is directly in the domain of clinical psychology. If Dr. Mercer renders any opinion regarding borderline personality disorder, she is once AGAIN practicing beyond the boundaries of her competence. **2.01 Boundaries of Competence** (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.
	MS. MOJADDIDI: Your Honor, if I may, I'd like to object as my understanding is that she was offered and admitted as an expert on attachment child development and unorthodox therapies.
	THE COURT: One rule I have, no speaking objections. Is your objection on relevance?
	MS. MOJADDIDI: No, Your Honor, I think it's beyond the scope of what she -
	THE COURT: Beyond the scope?
	MS. MOJADDIDI: I'm sorry, that's why I was reading the full one.
	THE COURT: That's all right.
	MS. MOJADDIDI: Beyond the scope of her expertise.
	THE COURT: So, again, my rule is to the objection is the word, your objection is beyond the scope of expertise. Mr. Myers, what is the response to that?
	MR. MYERS: Well, it's clearly not beyond the scope of expertise. She testified in her qualification process that although she's not a clinical psychologist, she's studied and taught principles of child development, and she's familiar with the diagnostic process.
	Dr. Childress Comment: It is clearly beyond her expertise. That exemption that "she's not a clinical psychologist" says it all right there. I don't care what she's "studied" as a hobby, or what she thinks she's "familiar with" – she is not professionally competent to render and opinion on that topic area. And this is not a legal issue. The court can decide whatever it wants regarding the admissibility of evidence. This is a professional issue for Dr. Mercer. This is a violation of the ethical code of the APA. It is her responsibility to defer an answer as beyond the scope of her competence. She has no training, education, or professional experience in any aspect of clinical psychology. She is not competent to render an opinion on pathology, its diagnosis, and treatment. **2.01 Boundaries of Competence** (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.
	THE COURT: Does your question about borderline personality disorder tie back to some of Kelly Frye issues?

	MR. MYERS: It is.
	THE COURT: I'll allow you to do so.

Dr. Childress Comment: I'm not a legal professional, but this would seem to be an error, she is not qualified as an expert in clinical psychology. The Kelly-Frye issue may be raised in a different context (it's not relevant, the Kelly-Frye challenge would be to attachment, family systems therapy, and personality pathology, all easily pass Kelly-Frye).

She is being allowed to testify outside the scope of her qualifications – and competence.

	MR. MYERS Q: I'll just ask one question regarding borderline personality disorder. Your knowledge of the discipline of psychology, do we know what the etiology of borderline personality disorder it?

Dr. Childress Comment: She is once AGAIN in violation of Standard 2.01a, and once AGAIN the information she provides the court is false. She is presenting false information to the court.

Much about the etiology of borderline personality disorder is understood – Kernberg, Millon, Beck, Linehan.

Here is what Aaron Beck says about the etiology:

> From Beck: "Various studies have found that patients with BPD are characterized by disorganized attachment representations (Fonagy et al., 1996; Patrick et al, 1994). Such attachment representations appear to be typical for persons with unresolved childhood traumas, especially when parental figures were involved, with direct, frightening behavior by the parent. Disorganized attachment is considered to result from an unresolvable situation for the child when "the parent is at the same time the source of fright as well as the potential haven of safety" (van IJzendoorn, Schuengel, & Bakermans-Kranburg, 1999, p. 226). Some traumatic experiences may have taken place at a very early age, notably the kind of punishing, abandoning, rejecting responses of the caretaker that led to disorganized attachment." (p. 191)

Research Linking Borderline Personality Disorder to Insecure Attachment

Brennan, K.A. and Shaver, P.R. (1998). Attachment Styles and Personality Disorders: Their Connections to Each Other and to Parental Divorce, Parental Death, and Perceptions of Parental Caregiving. *Journal of Personality* 66, 835-878.

Brennan & Shaver: *"Research on attachment and personality disorders.* In the clinical literature, there is increasing support for conceptualizing personality disorders as disorders of

attachment (e.g., Heard & Lake, 1986; Shaver & Clark, 1994; West & Sheldon, 1988; West & Sheldon-Keller, 1994). There is growing empirical evidence connecting Borderline personality disorder with patterns of insecure attachment reflected in representations of childhood relationships with parents (Patrick, Hobson, Castle, Howard, & Maughan, 1994; Sack et al., 1996; Stalker & Davies, 1995; West et al., 1994). Patrick et al. (1994) assessed internal representations of attachment (via the AAI; George et al., 1984/1985/1996) and found that individuals classified as Borderline evinced the mental organization characteristic of preoccupied attachment. Stalker and Davies (1995) found the same pattern in a small, clinical sample of sexually abused women. (p. 840)

Carlson, E.A., Edgeland, B., and Sroufe, L.A. (2009). A prospective investigation of the development of borderline personality symptoms. Development and Psychopathology, 21, 1311-1334

From Carlson, Edgeland, & Sroufe: " In contrast, borderline personality symptoms were significantly related to early relational experiences previously reported in retrospective studies. These included attachment disorganization (12–18 months) and maltreatment (12–18 months), maternal hostility and boundary dissolution (42 months), family disruption related to father presence (12 – 64), and family life stress (3 – 42 months)." (p. 1328)

Fonagy, P., Luyten, P., and Strathearn, L. (2011). Borderline personality disorder, mentalization, and the neurobiology of attachment. Infant Mental Health Journal, 32, 47-69.

From Fonagy, Luyten, & Strathearn: "Depending on the issue of different secondary attachment strategies and contextual factors, some BPD patients will be primarily characterized by preoccupied or avoidant attachment while the attachment system will be disorganized (either from infancy or as a consequence of subsequent stress) in other individuals. (p. 49)

Sable, P. (1997). Attachment, detachment and borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 34*(2), 171-181.

From Sable: Borderline personality disorder is conceived as a condition of profound insecure attachment". (p. 173)

Holmes, J. (2004). Disorganized attachment and borderline personality disorder: a clinical perspective. Attachment & Human Development, 6(2), 181-190.

Fonagy, P., Luyten, P., and Strathearn, L. (2011). Borderline personality disorder, mentalization, and the neurobiology of attachment. Infant Mental Health Journal, 32, 47-69.

Fonagy, P., Target, M., Gergely, G., Allen, J.G., and Bateman, A. W. (2003). The developmental roots of Borderline Personality Disorder in early attachment relationships: A theory and some evidence. Psychoanalytic Inquiry, 23, 412-459.

Herman, J.L., Perry, C., & van der Kolk, B.A. (1989). Childhood trauma in borderline personality disorder. American Journal of Psychiatry, 146, 490-495

Jellema, A. (2000). Insecure attachment states: Their relationship to borderline and narcissistic personality disorders and treatment processes in cognitive analytic therapy. Clinical Psychology and Psychotherapy, 7, 138-154.

Levy, K.N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. Development and Psychopathology, 17, p. 959-986

Linehan, M. M. & Koerner, K. (1993). Behavioral theory of borderline personality disorder. In J. Paris (Ed.), *Borderline Personality Disorder: Etiology and Treatment*. Washington, D.C.: American Psychiatric Press, 103-21.

Masterson, J.F. & Rinsley, D.B. (1975). The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. International Journal of Psychoanalysis, 56, 163-177

Zanarini, M. C., Williams, A. A., Lewis, R. E., Reich, R.B., R, B. R., & al, e. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *The American Journal of Psychiatry, 154*(8), 1101-6.

Agrawal, H.R., Gunderson, J., Holmes, B.M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. *Harvard Review of Psychiatry, 12,* 94-104.

Barnow, S. Aldinger, M., Arens, E.A., Ulrich, I., Spitzer, C., Grabe, H., Stopsack, M. (2013). Maternal transmission of borderline personality disorder symptoms in the community-based Griefswald Family Study. Journal of Personality Disorders, 27, 806-819,

Additional research has also linked the development of borderline personality disorder to sexual abuse victimization:

Bailey, J.M. and Shriver, A. (1999). Does childhood sexual abuse cause borderline personality disorder? Journal of Sex & Marital Therapy, 25, 45-57)

Ogata, S. N., Silk, K. R., Goodrich, S., Lohr, N. E., Westen, D., & Hill, E. M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *The American Journal of Psychiatry, 147*(8), 1008-13.

Trippany, R.L., Helm, H.M. and Simpson, L. (2006). Trauma reenactment: Rethinking borderline personality disorder when diagnosing sexual abuse survivors. Journal of Mental Health Counseling, 28, 95-110.

	A: No. There have been a lot of discussions, but it's not well understood.
	Dr. Childress Comment: No, that is not true. Borderline personality disorder is substantially understood. She is providing false information to the court.
	Q: Are you familiar similarly with narcissistic personality disorder?
	A: Yes.
	Dr. Childress Comment: Same as with borderline personality disorder, she is not a clinical psychologist, so she is rendering an opinion beyond the boundaries of her competence – a violation of Standard 2.01a of the APA ethics code.
	Q: Do you know what the etiology of narcissistic personality disorder is?
	Dr. Childress Comment: She is once AGAIN in violation of Standard 2.01a of the APA ethics code.

Narcissistic personality disorder is a sub-group of borderline personality disorder: From Kernberg: "One subgroup of borderline patients, namely, the narcissistic personalities… seem to have a defensive organization similar to borderline conditions, and yet many of them function on a much better psychosocial level." (p. xiii) Kernberg, O.F. (1975). Borderline conditions and pathological narcissism. New York: Aronson.	
	A: No. Once again, there are many suggestions but not much in empirical evidence.
	Q: Now, have experts in attachment studied the relationship between attachment in young children and the development of mental illness in adults?
	A: Yes, they have.
	Q: I want to take you through a some of a laborious process which I hope we can do with some of minor's counsel's exhibits. I'm going to ask you to direct your attention to minor's counsel's Exhibit 203.
	A: Okay.
	Q: Your Honor, at this point so that I can explain to the court what I'm attempting to do, there's a series of articles from professional literature in here, the witness I believe will testify that she has relied on these in part to formulate her opinions which she will offer in due course in this matter. I will offer them for the truth. I suspect that there will be an objection to that. I will also offer them as a basis for her part of the basis for her opinion testimony and in that case I would argue if there's a Sanchez objection that Sanchez clearly does not apply because she will not be discussing any case specific details. It will just be general information to which Sanchez does not apply.
Counsel and the court then discuss admissibility of evidence. This section has been extracted and placed as an Appendix to this analysis, since it is only marginally related to the matter under consideration.	
Resume Testimony	
	Q: So directing your attention, Doctor, to minor's Exhibit 3 in your binder, are you familiar with minor's exhibit, I'm sorry, 203?
	A: Yes.
	Q: All right. And for the record, this is an article titled Disorganized Attachment and Infancy, a review of the phenomenon and it's implications for commissions and policy makers. Doctor, this appears in a journal called attachment and human development, are you familiar with that journal?

	A: Yes, I am.
	Q: Are you familiar with its stature in the scientific community?
	A: It's an extremely important peer review journal.
	Q: All right. Now, you'll notice there that there are probably 25 to 40 authors of this particular article?
	A: Uh-huh.
	Q: Do you recognize any names among those offers?
	Dr. Childress Comment: This entire line of questions has no relevance.
	A: I certainly do. This is quite a panoply of the biggest names in attachment theory and research.
	Q: All right. Now, I would ask you to turn to page 535 in that article.
	A: Okay.
	Q: And number 1, now, Your Honor, I'll ask the court's guidance here, I'm going to ask the witness to either read this and again for this limited purpose, the court hasn't ruled on it or I can read it.
	THE COURT: It's your preference. I understand under Sanchez this is not case specific so I would allow her to read it if you would like.
	Dr. Childress Comment: I'm not a legal professional, but it seems to me that minor's counsel will simply use Dr. Mercer to enter into the record a lot of journal quotes as evidence (of questionable relevance). If I follow the argument in Appendix 1, it's that Dr. Mercer relied on this information in forming her opinions. First, her opinions about the work of a clinical psychologist are beyond her competence – but second, these articles don't apply to anything remotely involved in this case. Dr. Mercer didn't rely on these articles because they are of no relevance to the current matter.
	MR. MYERS: I would prefer to have the doctor read it, Your Honor.
	THE COURT: Thank you.
	MR. MYERS: So under the summary of 10 topics to be elaborated upon in this review, do you see number one?
	A: Yes.

	Q: Would you read number one with the exception of the last paragraph for the record?
	A: The disorganized infant attachment category can be assigned by trained and certified coders to infant behavior in 12 to 20 months in a strange situation where there's a sufficient fit for one or several of the behaviors listed under Main and Solomon.
	Dr. Childress Comment: That has no relevance to anything.
	Q: Now, are Main and Solomon the psychologists who came up with disorganized attachment as a category?
	A: Yes.
	Q: Now, when you were preparing your testimony for today, did you rely upon this article as part of the basis for your opinion?
	A: Yes, I did.
	Dr. Childress Comment: No, she didn't. That article has no relevance to anything about this case. She probably never even heard of it until minor's counsel supplied it to her. Notice, in a little bit he'll note that they "discussed" her testimony. I suspect he provided her with these articles and asked her to testify that she "relied" on these articles in forming her opinion, so that he could introduce the evidence of his own devising. But I'm not sure what that evidence is. After tracking the flow of his evidence, there's no there - there. It doesn't lead anywhere. Why does he care about the Strange Situation in infancy, the case is a post-divorce family conflict involving adolescents.
	Q: Including that sentence that you just read?
	A: Yes.
	Q: Now, I would direct your attention to page 537, this will be very brief, on page 537 and I'll just read it to you in this case just in case it's difficult to find, this is in the second full paragraph on 537, classification is truly widespread. Are the authors talking about disorganized attachment?
	A: Yes, they are.
	Q: And would you agree that misinformation about disorganized attachment is truly widespread?
	A: Absolutely.

	Dr. Childress Comment: What? Hardly anyone outside of the field of attachment has even heard of disorganized attachment. There's no "misinformation" out there about it. The court is being presented with false and misleading information.
	Q: Can you characterize to the court what the misinformation is?
	A: The misinformation is really two-fold, one is to assume that disorganized attachment is much more common than it actually is.
	Dr. Childress Comment: Who does that? First, no one even knows about disorganized attachment unless you somehow work with attachment pathology, and if you work with attachment pathology you understand the prevalence rates. She's assuming things because… she's not a clinical psychologist and she's never worked with attachment pathology – ever.
	A: The second one is to assume the disorganized attachment behavior of necessity indicates specific types of early experience that the child has had,
	Dr. Childress Comment: That, is actually not "misinformation" – that's actually true. We understand what type of parenting creates all the different categories of attachment, including disorganized attachment. Dr. Ruth Lyons at Harvard describes the type of parenting that creates a disorganized attachment in a Table in her article: Lyons-Ruth, K., Bronfman, E. and Parsons, E. (1999). Maternal frightened, frightening, or atypical behavior and disorganized infant attachment patterns. *Monographs of the Society for Research in Child Development, 64,* (3, Serial No. 258). Dimensions of Disrupted Maternal Affective Communication 1. Affective Errors a. Contradictory cues, e.g., invites approach verbally then distances. b. Nonresponse or inappropriate response, e.g., does not offer comfort to distressed infant. 2. Disorientation (items from Main & Hesse, 1992) a. Confused or frightened by infant, e.g., exhibits frightened expression. b. Disorganized or disoriented, e.g., sudden loss of affect unrelated to environment. 3. Negative-Intrusive Behavior (including frightening items, Main & Hesse, 1992). a. Verbal negative-intrusive behavior, e.g., mocks or teases infant. b. Physical negative-intrusive behavior, e.g., pulls infant by the wrist.

	4. Role Confusion (includes items from Sroufe et al., 1985; Main & Hesse, 1992). a. Role-reversal, e.g., elicits reassurance from infant. b. Sexualization, e.g., speaks in hushed intimate tones to infant. 5.Withdrawal a. Creates physical distance, e.g., holds infant away from body with stiff arms. From Lyons-Ruth: "The mother's repeated failure to alter her caregiving behavior toward the infant in the face of clear and repeated infant cues should lead to disorganization of infant strategies whether the unresponsive maternal behavior is withdrawing, role-reversing, controlling, or rejecting in form." Professional psychology, and the research on attachment, understands the type of parent-child interactions that create disorganized attachment. What Dr. Mercer is telling the court is not true – it is false information.
	A: and the third one, sorry, and the third one is to assume that where there's disorganized attachment we can very reliably predict mental illness in adulthood.
	Dr. Childress Comment: No one believes that. That is a straw-man. Disorganized attachment is a risk factor, but it is not destiny. No one believes we can reliably predict mental illness in adulthood by any childhood factor. That's a straw-man. Of her three "misunderstandings," two are straw-men that no one believes, and one is actually true – we do know what causes disorganized attachment.
	Q: Now, that's an important one so let me ask you to elaborate on that. If I understood you correctly you said there's a misunderstanding between a finding of disorganized attachment in a strange situation and the prediction or the correlation of mental illness in adulthood?
	A: Exactly.
	Q: Can you explain that?
	A: The assumption that is too often made is that if you see disorganized attachment behavior in a toddler that we can predict with, you know, considerable accuracy that there will be mental illness developing in later life.
	Dr. Childress Comment: Who believes that? No one says that. That's a straw-man argument, making up something that's not true, and then attacking it. No one believes – no one says – that disorganized attachment

	in childhood predicts with "considerable accuracy" later mental illness – it's a risk factor, that's what we know. In addition, none of this is relevant to a post-divorce family conflict involving adolescents.
	Q: Can we not make that prediction?
	A: No, we cannot.
	Q: And what's the basis for your saying we cannot make that connection?
	A: Well, disorganized attachment like any other kind of attachment behavior may not show up on different testings. There's variability in all kinds of attachment behavior. In addition to that, there is high plasticity to any kind of attachment behavior which means that later experiences and later events are going to make a great deal of difference to the outcome. Disorganized attachment behavior is only one of many risk factors for the determination of later development of mental illness and by risk factor I mean that this is one item, one factor which in combination with other factors is going to bring about this determination. Where we have many risk factors operating together, you're much more likely to have mental illness. If we have only one or two risk factors much less likely to have mental illness as a result.
	Q: So would it be fair to say that a finding of disorganized attachment in a strange situation is not a fait accompli that this child is doomed to mental illness?
	Dr. Childress Comment: This is a post-divorce family conflict involving adolescent children. Why are they talking about disorganized attachment predicting mental illness in an adult? That's not what we're dealing with.
	A: That's exactly correct, and, in fact, there's one very interesting study that looks at the differences between children who are malnourished in the toddler period and those who are well nourished. We get a lot of malnourished kids who show disorganized attachment behavior, but by the time they get into later life there are no big differences between the two groups, maybe health differences, physical health differences and size differences, but you have a considerable amount of recovery or shall we say reshaping of their attachment behavior.
	Q: So now let me ask you, Doctor, to turn to page 542, and I think in the interest of making this quick since I know what I'm interested in and it may be hard for you to locate it, but I do need you to locate it, the first full paragraph on 542, did you rely upon this paragraph in formulating the opinions that you will offer today?
	Dr. Childress Comment: The perfunctory, "did you rely upon this…" when she actually didn't. Why would she rely on something about infant attachment when dealing with a post-divorce family conflict involving adolescents? Minor's counsel thinks he has a plan and wants to introduce

	this evidence, so he conspires with Dr. Mercer to say she "relied on it" in forming her opinions.
	A: Yes, I did.
	Q: I'm going to read a little bit of that paragraph, it says practitioners will wish to consider, and when it says say practitioners, are they talking about clinicians?
	A: Yes.
	Q: Practitioners will wish to consider what they can infer from a classification of disorganized attachment even if told by a certified attachment coder that an infant's behavior in a strange situation has received a disorganized classification, a practitioner can only infer that the infant has experienced alarm in relation to the caregiver for some reason and has a somewhat higher risk of social, emotional, developmental difficulties. Is that consistent with what you testified to a moment ago?
	Dr. Childress Comment: First, Dr. Mercer has never assessed, diagnosed, or treated any pathology, and certainly not attachment pathology. If we want to learn about how disorganized attachment presents in a clinical setting to a "practioner" – why don't we ask an actual practioner who HAS assessed, diagnosed, and treated disorganized attachment in children ages zero-to-five in the foster care system. That would be me, Dr. Childress. I was the Clinical Director for a three-university collaboration treatment center for children ages zero-to-five in the foster care system (Cal State San Bernardino, Loma Linda University, University of Redlands, through contracts with the Department of Behavioral health and Department of Children's Services. I have assessed, diagnosed, and treated all types of attachment-related pathology found in children ages 0-5 in foster care, including disorganized attachment. Why are we listening to someone who has never received any education or training in any aspect of clinical psychology, not assessment, not diagnosis, not treatment, and who has never worked with any attachment-related pathology in her entire life? Besides, the Strange Situation and diagnosing disorganized attachment in infancy has no relevance to a post-divorce family conflict involving adolescents.
	A: Yes, it is, and I just want to remind you of what I was saying earlier about the disorganized attachment behavior, that the child's behavior is coupled with alarming or frightened or frightening behavior on the part of the mother. If the mother can stop acting like that the child will also stop acting like that.

	Dr. Childress Comment: Once AGAIN, Dr. Mercer is rendering an opinion on clinical psychology, which is beyond her boundaries of competence. And it is also false information. If the mother "can stop acting like that" the child may already be significantly damaged emotionally and psychologically, and a repair process may be required before the "child will also stop acting like that." She knows nothing about attachment pathology.
	Q: Okay. Thank you. It also says on page 542, accordingly disorganized attachment with a particular caregiver is best thought of as a risk factor for later social and externalizing problems contributing as one factor among many others; is that true?
	Dr. Childress Comment: Of course it's true. Nobody on the planet will argue with that. You are constructing a straw man. Watch, they are then going to claim that I say that if a child has disorganized attachment, this means that automatically the child will develop narcissistic or borderline personality pathology. That will be a lie when they say it. It's not true. It's all a straw-man argument of deceit and false information told to the court.
	A: Yes.
	Q: And that's consistent with your own professional experience?
	Dr. Childress Comment: She has zero professional experience. She's taught general education psychology courses at a small college up until 2006. For the past decade she's been non-involved in professional psychology. She's not a clinical psychologist – she never has been a clinical psychologist, she has NO professional experience with attachment pathology. Minor's counsel is misrepresenting her to the court.
	A: Yes.
	Q: I just have two more on this one, Your Honor, maybe we should stop then.
	THE COURT: Very good.
	MR. MYERS: 540, also on 542 in that first paragraph it says a child assigned a disorganized classification is not necessarily expected to develop behavioral problems. Do you agree with that statement?
	A: Yes.
	Q: Did you rely on that statement in formulating your opinion?

	A: Yes.
	Q: Would the court wish me to stop at this point?
	THE COURT: Let's do. So we'll take a 15-minute break in the case returning at about 10:20. You can leave your papers here quite a bit of them so we'll be back here at 10:20 on that case. I'll now turn to the other cases.
	MR. MYERS: Thank you, Your Honor.
	MS. MOJADDIDI: Thank you.
	THE COURT: Dr. Mercer can come back on the stand as I'm making my notes here. Thank you for your patience. Dr. Mercer is back on the stand where she remains under oath. Mr. Myers, you have the floor.
	MR. MYERS: Thank you, Your Honor. For the information for my colleagues, I think my direct exam will be done before lunch.
	THE COURT: Thank you.
	MR. MYERS: So at this point, Your Honor, regarding minor's I believe it is 203, 203 sorry about that, at this point, Your Honor, I realize we discussed this to some extent I'm going to offer 203 into evidence for the truth of the matter asserted under Evidence Code 1341 just so that I make a record.
	THE COURT: Very good. It has been offered. I had a chance to look at Sanchez during the break which confirms that no case specific information can come in notwithstanding Sanchez's ruling but not for the truth.
	MR. MYERS: Right, and Your Honor -- I'm sorry.
	THE COURT: The other thing I found which is in looking at [citation] this section in theory authorizes sources to the jury however the practices are so strict that the section is rarely used and that may be why there aren't many cases, but Ms. Mojaddidi, you still need a bit more time to review these?
	MS. MOJADDIDI: Your Honor, the actual articles I do need to review but even the authority that was cited by Mr. Myers, the case that he cites [citation], in that case the court while they allowed her to read certain passages from the documents they were not allowed to be admitted into evidence because they were hearsay and they didn't follow the 1341 because they were not being offered to prove facts of general notoriety and interest and in that case it was medical journals so I would say that his own authority wouldn't allow for it but in go ahead.
	THE COURT: This is a --
	MS. MOJADDIDI: California.

	THE COURT: So Ms. Mojaddidi, you're reading of that case is the expert was allowed to read from the journals but the journal articles themselves were not admitted.
	MS. MOJADDIDI: Yes, Your Honor, and I can read that exact sentence. The court properly permitted the plaintiff to read passages from the documents and the documents they're referring to medical journals and the question the witness is concerning them without receiving the documents themselves into evidence and the statement right before that says because it was hearsay.
	THE COURT: So the trial court in that case key tied had not to admit them.
	MS. MOJADDIDI: Right.
	THE COURT: So it is not that the court of appeal reversed their admission. Mr. Myers, what's your thought on that?
	MR. MYERS: Well, my thought that if he says it it, it's probably true but he's one of the leading scholars on the law of evidence for sure but there isn't much authority on it and I guess what I'm doing is I'm trying to make a record because I'm trying to make some authority.
	THE COURT: Right.
	MR. MYERS: And I understand we have these dual tracks we're discussing as the basis for the doctors opinion only not for the truth of the matter asserted but then for the truth. I feel I'm obligated to offer them under 1341 and if the court you know sustains the objection I'm fine with that. I'll just make the offer of proof.
	THE COURT: Well, fair enough. Let me make a ruling so that we can move on. I will admit 203, not for the truth of the matter asserted but to show what Dr. Mercer has reviewed and relied upon. In my view it does not the facts developed in this article are not of general notoriety and interest.
Dr. Childress Comment: If we're allowed to admit articles and passages into evidence, I have a lot I'd like to submit that I relied on.	
	MR. MYERS: All right. Your Honor, I appreciate that and we can probably save time by just asking the court to make the same ruling for 204, 205, 206, 207 and 208.
	THE COURT: I will once she confirms she's reviewed them and relied upon them.
	MR. MYERS: Very good, Your Honor, and just for purposes of the record, I would ask the court's permission to attach them for the truth of the.
	THE COURT: You certainly may.
	MR. MYERS: Thank you, Your Honor.

	Q: Then I'll proceed by asking you, Dr. Mercer, to turn to 204 minor's 204.
	A: Okay.
	Q: And do you recognize the author of this article in the professional literature?
	A: Yes, I certainly do.
	Q: Would you say the author's name?
	A: To the best of my knowledge, it's pronounced Alan Sroufe.
	Q: Perfect. And he was also one of the article authors in the article we just finished with in minor's 203; is that correct?
	A: That's right.
	Q: And the article that we're looking at now in minor's 204 is attachment and development a prospective longitudinal study from birth to adulthood, are you familiar with Dr. Sroufe's work?
	A: Yes.
	Q: Are is he a psychologist?
	A: Yes, he is.
	Q: And do you know where he is employed?
	A: Yes. At the Institute for Child Development in University of Minnesota.
	Q: Where would you place him in the pantheon of experts on attachment?
	A: Way up at the top.
	Q: And has he been so for many years?
	A: Yes, he has been.
	Q: Now, is it this article that is referred to as minor's which is minor's 204, did you read this article in preparation for your testimony today?
	A: Yes, I did.
	Q: And did you rely upon it in part for the opinions that you will offer?
	A: Yes.

	Q: All right. Now, this article describes what is sometimes called the Minnesota study; is that right?
	A: Yes.
	Q: And can you explain briefly to the court what this study is?
	A: Well, this is a rather unusual kind of study, it's a difficult to do, it's a longitudinal study which means that it's taking a group of children, actually, the mothers were contacted before the children were born and it's followed these people through childhood, through adolescence and right up into adulthood, so this offers an opportunity to look for whether the quality of attachment for these children when they were toddlers was a predictor of any specific personality or mental health issues in adulthood.

Dr. Childress Comment: Alan Sroufe has a phenomenal longitudinal research project on attachment. Here are some relevant statements Sroufe, along with his colleagues Carlson and Edgeland, make:

From Carlson, Edgeland, & Sroufe: "In contrast, borderline personality symptoms were significantly related to early relational experiences previously reported in retrospective studies. These included attachment disorganization (12–18 months) and maltreatment (12–18 months), maternal hostility and boundary dissolution (42 months), family disruption related to father presence (12 – 64), and family life stress (3 – 42 months). (p. 1328)

Carlson, E.A., Edgeland, B., and Sroufe, L.A. (2009). A prospective investigation of the development of borderline personality symptoms. Development and Psychopathology, 21, 1311-1334

	Q: Were the kids in this study, did they undergo the strange situation?
	A: Yes.
	Q: Is this as far as you know the only set longitudinal study of its kind?
	A: Yes, I think it is.
	Q: All right. Now I'm going to ask you to look at a couple of places just as we did with the previous article, if you would turn to page 350 in this article about this is the first paragraph at the top of the page, do you see that paragraph?
	A: Starting it may not be as widely known?
	Q: Yes, and then about 4 lines down it states there and I'll just read it, and then I'll ask you a question, Bowlby's, this would be John Bowlby?

	A: Yes.
	Q: Bowlby's viewpoint is most succinctly summarized by a quotation from the second volume, when it says the second volume, this is the second volume of Dr. Bowlby's treatises of attachments; is that right?
	A: Yes.
	Q: He says that the developmental pathway chosen turns at each and every stage of the journey on an interaction between the organism as it has developed up to that moment in the environment in which it then finds itself, is this a statement which is in accord with your experience and understanding?

Dr. Childress Comment: First, she has no experience. Second, if we want to cite Bowlby, how about this one:

> From Bowlby: "The deactivation of attachment behavior is a key feature of certain common variants of pathological mourning" (Bowlby, 1980, p. 70)

A child rejecting a parent is a "deactivation of attachment behavior" – we therefore know it's caused by "pathological mourning."

Who's pathological mourning? The child's? Mourning for who? For the lost relationship to the targeted parent.

So the treatment answer becomes to restore the parent-child bond as quickly as possible and resolve the pathological mourning. The treatment for mourning is NEVER to maintain a separation and loss – it's always to repair the separation and restore the bond.

Is there something else that Bowlby says about "disordered mourning" that would be helpful? Yes. He links disordered mourning to personality pathology.

> From Bowlby: "Disturbances of personality, which include a bias to respond to loss with disordered mourning, are seen as the outcome of one or more deviations in development that can originate or grow worse during any of the years of infancy, childhood and adolescence." (p. 217)

So perhaps it's not the child who has pathological mourning, it's the allied parent surrounding the divorce, and that this allied parent is transferring this disordered mourning process to the child through aberrant and distorted parenting practices.

How should we assess for that? Maybe we should ask a clinical psychologist who has specialized in working with attachment pathology in the foster

	care system.
	A: Yes, it is, and this is what I meant when I refer to the plasticity of attachment. It's constantly being reshaped by events both in the environment and the maturation of the person.
	Q: Now, if you would turn to page 359.
	A: Okay.
	Q: At the bottom of the page, well, at the bottom of the page and I'll read to you and, first of all, did you read this and is this something you relied upon in formulating your opinion?
	A: Yes.
	Q: And also to avoid repeating that question, in all the articles that I'm going over with you, did you and I discuss them?
	Dr. Childress Comment: She didn't rely on infant attachment studies to inform her opinion about post-divorce family conflict involving adolescents. She's not even a clinical psychologist who could speak to the assessment, diagnosis, and family conflict surrounding divorce. I suspect minor's counsel provided her with the articles and discussed what he wanted her to testify about. I don't think she actually relied on any of these article. I think she's lying to the court.
	A: Yes.
	Q: And what would your answer be to the question did you rely upon this article or this particular passage in formulating your opinion?
	A: Yes, I did.
	Q: So with the court's permission, I'll dispense with asking that question repetitively.
	THE COURT: You may.
	MR. MYERS: And at the bottom of 359, and I'll read to you, in terms of the discipline of developmental psychopathology attachments are viewed as potential risk factors related to certain studies, they are not viewed as pathological in themselves or is inevitably leading to pathology but is conditions that increment the probability of disturbance compared to the general population. That seems to be consistent to what your testimony has already been?

	Dr. Childress Comment: Notice all he has to do is feed her the lines, and she says, "Yes." No body argues with this. It is a straw-man they are constructing.
	A: Yes.
	Q: Would I be correct in summarizing that to say that insecure attachment does not necessarily lead to mental illness?
	Dr. Childress Comment: A complete straw-man. No one disagrees with that. I am in 100% agreement with that. Everybody is.
	A: Absolutely.
	Q: Would that be true for disorganized attachment as well?
	A: Yes.
	Q: I think that will take care of that one. I'm not going to read all of them in the interest of time. S o directing your attention to minor's 205.
	A: Yes.
	Q: Are you familiar with this article from the literature?
	A: Yes.
	Q: Are you familiar with the two authors?
	A: Yes
	Q: I can't pronounce the first author's name so may I impose on you to do so?
	A: Mikulincer
	Q: Is Mario Mikulincer an authority on attachment?
	A: Yes, especially on attachment in adulthood.
	Q: And how about Phillip Shaver, is Phillip Shaver an expert on attachment?
	A: Yes.
	Q: Now, this article is called an attachment prospective on psychopathology, and it appears in a journal called world psychiatry. I would just ask you very briefly from this article to turn to page 12.

	A: Okay.
	Q: And in the first column on page 12 under attachment mental health and psychopathology, I'll read the following statement, attachment insecurity can therefore be viewed as a general vulnerability to mental disorders with a particular symptomatology depending on genetic, developmental and environmental factors, is that consistent with your knowledge of attachment?
	A: Yes, it is.
	Q: And then at the bottom of page 212 in had the right-hand column I will read, overall attachment insecurities seem to contribute nonspecifically to many types of psychopathology, is that a true statement?
	A: Yes, it is.
	Q: So would it be fair to say, Doctor, that a clinician or an experimenter when you see insecure or disorganized attachment this is something to be concerned about, would that be a fair statement?
	Dr. Childress Comment: A straw man. I agree with everything they've quoted. Watch, they'll claim I make some outrageous claim that childhood attachment pathology ALWAYS leads to adult pathology. The straw-man. That's not true, but that's what they are conspiring together to present to the court. That's their "relevance" of all this infant disorganized attachment references from infancy – in a case about post-divorce family conflict in adolescents. Minor's counsel thinks he's found some convoluted hole in Dr. Childress' "theory." They are going to deceive the court. Watch.
	A: Yes.
	MS. MOJADDIDI: Objection, lacks foundation
	THE COURT: Overruled.
	MR. MYERS Q: All right. I think that answers the question. So now I would ask you to turn to minor's 206.
	A: Okay.
	Q: Now, so you have 206?
	A: Yes.

	Q: Now, this is a book, is it not, the handbook of attachment?
	A: Yes.
	Q: And there are two editors, Jude Cassidy and Phillip Shaver?
	A: Uh-huh.
	Q: Are you familiar with these authors?
	A: Yes. Both well-known figures in the attachment theory world.
	Q: And the full title of the handbook is Attachment Second Edition Theory, Research. and Clinical Applications. Are you familiar with the Guilford Press?
	A: Yes.
	Q: Where this book was published, is this a respected publishing house?
	A: Yes, it publishes many psychologists and psychological research books.
	Q: Okay. Let me ask you to turn to page 656, and I'll just have one quote that I want to read from this page. Are you there yet?
	A: Yes.
	Q: On page 656 under conclusions we find the statement, attachment insecurity appears to be an important but nonspecific factor that increases risks for several forms of childhood psychopathology, there are insufficient longitudinal data from infancy to establish with certainty that specific pathways exist between early attachment types and differing forms of psychopathology. Is that statement again consistent with your understanding and with the other articles that we've referred to today?

Dr. Childress Comment: The fallacy that they're both working under is that diagnosis is made by etiology. They are trying to track childhood causes to adulthood pathology – but that's not the way diagnosis works.

Diagnosis works the other direction. It starts with symptoms and symptom patterns and works it's way back to causes. Start with symptoms. Explain the symptioms, that's diagnosis.

But Dr. Mercer has never had any coursework or any training in assessment, diagnosis, and treatment of pathology. She has never assessed, diagnosed, or treated any pathology.

In her imagination, she thinks it's about being some sort of sleuth to uncover causes. No, we stay with the symptoms. Diagnosis is anchored in current symptoms. We then explain the current symptoms.

	Their fundamental flaw is that neither one of them is a clinical psychologist. Neither one knows anything about the assessment, diagnosis, and treatment of pathology.
	A: Yes, it is, and I want to point out that they talk about risk for several forms of childhood psychopathology, you're not talking about adult psychopathology here.
	Q: Let me direct your attention to page 657. In the second full paragraph on the left-hand column about 8 lines down and I'll read, quote, with few exceptions however, insecure attachment is unlikely to be either a necessary or a sufficient cause of later disorder and in some cases it may be an effect of the disorder itself. End quote. Is that consistent with what we've been reading so far?
	A: Yes, it is.
	Q: Two more to go, it won't take much time. Minor's 207, this is the same book; am I correct?
	A: Yes.
	Q: And I made a mistake, Doctor, I'm going to have to ask you to go back to 206 just briefly if you would because I asked you about the two editors of the book, but I did not ask you about the authors of the chapter that I read from so that would be on page 637 the beginning of --
	A: Right.
	Q: Do you recognize Michelle Declian and/or Mark Greenberg?
	A: Michelle Declian.
	Q: Sorry.
	A: Yes. Actually, I know her, and Mark Greenberg was her professor and mentor and is very well-known for his work in preschool attachment.
	Q: All right. Very good. Thank you, Doctor. So then I will ask you to turn in minor's 207 which I would represent to the court is from the same Handbook on Attachment that the doctor's already described and ask you to turn to the first page of that article which is actually chapter 30, and it says the authors are Mary Dosier, Chase Stovall McClue and Cathleen Halvas, do you recognize any of those?
	A: Yes, all of them.
	Q: And how do you recognize them?
	A: Well, Mary Dosier is the developer of one seriously effective treatment for children with problems of attachment in toddler life.

	Q: All right. Very good. Now, this article interestingly contains some specific, this chapter specific discussion of disorganized -- disassociated symptoms rather, I beg your pardon. If you would turn to page 728, the right-hand column, the last paragraph says one predictor of dissociative symptoms is disorganized disoriented attachment in infancy.
	A: Yes.
	Q: Do you agree with that statement?
	A: If we're talking about dissociative symptoms in adulthood I think they are.
	Dr. Childress Comment: She is not a clinical psychologist and yet she is rendering an opinion about dissociative disorders and pathology. She is way-way beyond her boundaries of competence. Again, another violation of Standard 2.01a of the APA ethics code.
	Q: Yes.
	A: Yes.
	Q: And that's important given the facts that they will develop in this case, could you explain a little bit what your understanding of one predictor of disassociated symptoms?
	A: Well, the predictor they're talking about here is that the child has displayed disorganized attachment behavior in the toddler period.
	Q: And then over on page 729, there's two quotes that I want to mention both of which are going to deal with disassociation in an adult, the first is on page729 in the second column, it's a very long, long paragraph, about a third of the way from the bottom of that paragraph it says disorganized attachment accounted for 34 percent of the variance in later disassociated symptoms.
	A: Uh-huh.
	Q: Do you agree with that statement?
	Dr. Childress Comment: There's nothing to really agree with in that, it's the findings of a research study. The relevance is strained. This matter is a post-divorce family conflict involving adolescent children. There is no disorganized attachment disorder made.
	A: Well, if you add the middle part combined with infancy of internal emotional availability. They're not saying that disorganized attachment alone accounting for that variance.
	Q: And could you explain to me at least as a layman what 34 percent of the variance would mean?

	A: Okay. What they mean is that when you look at the correlation, the actual, you know, statistical calculation of correlation between the assessment that was given of the child's disorganized behavior and their later associative symptoms and you take that number so a correlation is always going to be somewhere between zero and 1.0, you take that number and you square it so because this is, it's going to be a decimal, you're going to come out with a smaller number than you started with, that's how you calculate the amount of the variance. The variance means really what it sounds like, the variability in symptoms that people show and the variability in connection between the early measurement and the associative symptoms.
	Dr. Childress Comment: Any relevance is gone. That 34% of variance in the later development of dissociative symptoms is accounted for by disorganized attachment is not relevant to anything. It's a high proportion. Disorganized attachment is strongly associated with later dissociative symptoms. That one factor can account for a third of the variance in a symptom's development, that's a strongly linked factor.
	Q: Can you explain to me as a layperson what 34 percent variance means?
	A: It means that the whole variance is going to be 100 percent so 100 percent minus 34 percent gives us what, 66 percent left over. 66 percent of the difference is among people were caused by something other than these two factors that they're talking about
	Q: All right. Now, I think I get what that means. Thank you, Doctor. So one final article and we'll be done with this exercise and move on to something else and that's minor's 208 which I would represent to the court is a chapter from the same book that we've been discussing handbook of attachment, can you turn to the beginning of that chapter?
	A: Yes.
	Q: Do you recognize any of the names there?
	A: Yes, I recognize all of them.
	Q: And are they experts on attachment?
	A: Yes, they are.
	Q: All right. One of them is the same Allen screw /TPAEU that we've been discussing?
	Dr. Childress Comment: I'm not a legal professional, but it seems odd that minor's counsel does not need to call these experts as witnesses and subject them to direct and cross-examination, but is instead allowed to enter their selected "testimony" with commentary and interpretation by Dr.

	Mercer, without any capacity for direct or cross-examination of the actual expert. That seems odd.
	A: Right.
	Q: And is this book if you would turn to page 90 in this chapter rather, if you would turn to page 90.
	A: Okay.
	Q: On page 90 on the second column under infant attachment and psychopathology, I'll read briefly in the concepts presented here, adapted from Bowlby, individual differences in infant attachment quality are not viewed as inherently pathological or nonpathological. In the pathways perspective, the hypothesis is that patterns of insecure attachment represents initiations of pathways that if pursued will increase the likelihood of pathological conditions. Is that a nice summary of what we've been discussing so far?
	A: Yes.
	Q: Now, Doctor, I thank you for your patience and the court's indulgence in that exercise. I'm going to ask you now a couple of questions, Doctor, as follows, I'll begin here, based on the professional literature and your own research and experience, can you briefly summarize the connection between disorganized attachment and mental illness in adults?
	Dr. Childress Comment: What was the relevance and point of that "exercise"?
	A: Well, once again, disorganized attachment is one of the many risk factors that help to determine whether someone will be mentally ill in adulthood. Other risk factors would be genetic problems that the person has, temperamental problems which refers to their basic personality and responsiveness to the environment and, of course, millions of experiences that they will have as they're growing into adulthood including circumstances like exposure to war or domestic violence or unusual success in school, you know, there are going to be positive factors here as well as negative ones, that all of those work together to determine what their mental health will be in adulthood.
	Dr. Childress Comment: See how they're working cause from source to outcome. That's not how we make a diagnosis. We work the other way. We start with symptoms. If the symptoms meet a specified pattern they receive a diagnosis. If we seek the cause of symptoms, we start by explaining how those symptoms develop. There's a lot of directions that a world can take in its formation. But if we find seashells at the top of a mountain, there's only one explanation. Can we predict that a seashell at the floor of the ocean will one day be embedded in a mountain? No, seashells have varied fates. But if we find

	seashells in the rocks at the top of a mountain (the symptom), there's only one explanation for how they got there. Minor's counsel and Dr. Mercer are working the wrong direction, because neither one knows anything about pathology and clinical psychology. Neither one has ever received any education or training in the assessment, diagnosis, and treatment of pathology, and neither one has ever actually assessed, diagnosed, or treated any pathology.
	Q: Thank you. Now, Doctor, in your opinion to a reasonable degree of scientific certainty, what is the gold standard scientifically valid way to assess attachment of a young child?
	A: There's only one thing that's ever called the gold standard and that is the strange situation paradigm.
	MS. MOJADDIDI: I'm sorry, I didn't hear the first word, strength?
	MR. MYERS: Strange.
	MS. MOJADDIDI: Strange. Okay. I thought she said strength. Thank you.
	MR. MYERS: In your opinion to a reasonable degree of scientific certainty, can a mental health professional accurately determine what type of attachment an adult had as a baby by interviewing the adult?
	A So you're asking if you can retrospectively identify and that's no
	Dr. Childress Comment: That's not true. It's called the *Adult Attachment Interview*. What Dr. Mercer said is false. She is giving the court false information. The Adult Attachment Interview can identify the adult's attachment pattern by interviewing the adult about their childhood experience.

	Q: And why is that?
	A: Because there's many other ways in which the person's mental health was shaped as time went on, I mean, you're talking about 20 years at least of experiences as the person gets older, and all of those are going to determine what happens, so to assume that you could, you know, look at what's going on in adulthood and pick out one of the many risk factors that had occurred in childhood that would assume for one thing that this was a linear process so that the connection, you know, the correlation was very, very high between them, and it would also assume that there is no plasticity that once you have this happen, you know, you're doomed or undoomed depending on which way it goes.
	Dr. Childress Comment: The Adult Attachment Interview.

	And I assume, am I correct in understanding your testimony that it is not a linear process from attachment to mental health problems?
	Dr. Childress Comment: Of course it's not. The straw-man.
	A: That's absolutely correct, and not only is it nonlinear, it's usually referred to as bidirectional, that is, the environment affects the child, the child affects the environment.
	Q: Now, in your opinion to a reasonable degree of scientific certainty, does disorganized attachment in a toddler lead directly to narcissistic personality disorder?
	Dr. Childress Comment: First, she is not qualified to answer that question about pathology, she is not a clinical psychologist. She has once AGAIN violated Standard 2.01a of the APA ethics code for practice beyond the boundaries of her competence. Second, nothing leads "directly" to any pathology. It is a straw-man set up. They are going to say that I claim a direct causal connection. That will be the false assertion to the court. They are setting up that straw-man, and then they are going to claim that I say the opposite. That is not true. That is false. How about indirectly?
	A: No.
	Q: Is it a risk factor for narcissistic behaviors?
	A: I have not seen any evidence that it is.

Brennan, K.A. and Shaver, P.R. (1998). Attachment Styles and Personality Disorders: Their Connections to Each Other and to Parental Divorce, Parental Death, and Perceptions of Parental Caregiving. *Journal of Personality* 66, 835-878.

> Brennan & Shaver: *"Research on attachment and personality disorders.* In the clinical literature, there is increasing support for conceptualizing personality disorders as disorders of attachment (e.g., Heard & Lake, 1986; Shaver & Clark, 1994; West & Sheldon, 1988; West & Sheldon-Keller, 1994).

Jellema, A. (2000). Insecure attachment states: Their relationship to borderline and narcissistic personality disorders and treatment processes in cognitive analytic therapy. Clinical Psychology and Psychotherapy, 7, 138-154.

Smolewska, K. and Dion, K.L. (2005). Narcissism and adult attachment: A multivariate approach. Self and Identity, 4, 59-68.

Diamond, D., Levy, K. N., Clarkin, J. F., Fischer-Kern, M., Cain, N. M., Doering, S., . . . Buchheim, A. (2014). Attachment and mentalization in female patients with comorbid

narcissistic and borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment, 5*(4), 428-433.

Lyddon, W. & Sherry, A. (2011). Developmental Personality Styles: An Attachment Theory Conceptualization of Personality Disorders. Journal Counseling and Development.

Bennett, S.C. (2006). Attachment theory and research applied to the conceptualization and treatment of pathological narcissism. Clinical Social Work Journal.

Narcissistic pathology is a variant, a subgroup, of borderline personality pathology:

> From Kernberg: "One subgroup of borderline patients, namely, the narcissistic personalities… seem to have a defensive organization similar to borderline conditions, and yet many of them function on a much better psychosocial level." (p. xiii)

Kernberg, O.F. (1975). Borderline conditions and pathological narcissism. New York: Aronson.

All of the research linking disorganized attachment to borderline pathology is also applicable to narcissistic personality disorder.

	Q: In your opinion to a reasonable degree of scientific certainty, does disorganized attachment cause borderline personality disorder?
	A: No.

From Beck: "Various studies have found that patients with BPD are characterized by disorganized attachment representations (Fonagy et al., 1996; Patrick et al, 1994). Such attachment representations appear to be typical for persons with unresolved childhood traumas, especially when parental figures were involved, with direct, frightening behavior by the parent. Disorganized attachment is considered to result from an unresolvable situation for the child when "the parent is at the same time the source of fright as well as the potential haven of safety" (van IJzendoorn, Schuengel, & Bakermans-Kranburg, 1999, p. 226). Some traumatic experiences may have taken place at a very early age, notably the kind of punishing, abandoning, rejecting responses of the caretaker that led to disorganized attachment." (p. 191)

Brennan, K.A. and Shaver, P.R. (1998). Attachment Styles and Personality Disorders: Their Connections to Each Other and to Parental Divorce, Parental Death, and Perceptions of Parental Caregiving. *Journal of Personality* 66, 835-878.

> Brennan & Shaver: *"Research on attachment and personality disorders.* In the clinical literature, there is increasing support for conceptualizing personality disorders as disorders of attachment (e.g., Heard & Lake, 1986; Shaver & Clark, 1994; West & Sheldon, 1988; West & Sheldon-Keller, 1994). There is growing empirical evidence connecting Borderline personality disorder with patterns of insecure attachment reflected in representations of childhood relationships with parents (Patrick, Hobson, Castle, Howard, & Maughan, 1994; Sack et al., 1996; Stalker & Davies, 1995; West et

al., 1994). Patrick et al. (1994) assessed internal representations of attachment (via the AAI; George et al., 1984/1985/1996) and found that individuals classified as Borderline evinced the mental organization characteristic of preoccupied attachment. Stalker and Davies (1995) found the same pattern in a small, clinical sample of sexually abused women. (p. 840)

Carlson, E.A., Edgeland, B., and Sroufe, L.A. (2009). A prospective investigation of the development of borderline personality symptoms. Development and Psychopathology, 21, 1311-1334

From Carlson, Edgeland, & Sroufe: " In contrast, borderline personality symptoms were significantly related to early relational experiences previously reported in retrospective studies. These included attachment disorganization (12–18 months) and maltreatment (12–18 months), maternal hostility and boundary dissolution (42 months), family disruption related to father presence (12 – 64), and family life stress (3 – 42 months)." (p. 1328)

Fonagy, P., Luyten, P., and Strathearn, L. (2011). Borderline personality disorder, mentalization, and the neurobiology of attachment. Infant Mental Health Journal, 32, 47-69.

From Fonagy, Luyten, & Strathearn: "Depending on the issue of different secondary attachment strategies and contextual factors, some BPD patients will be primarily characterized by preoccupied or avoidant attachment while the attachment system will be disorganized (either from infancy or as a consequence of subsequent stress) in other individuals. (p. 49)

Sable, P. (1997). Attachment, detachment and borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 34*(2), 171-181.

From Sable: Borderline personality disorder is conceived as a condition of profound insecure attachment". (p. 173)

Holmes, J. (2004). Disorganized attachment and borderline personality disorder: a clinical perspective. Attachment & Human Development, 6(2), 181-190.

Fonagy, P., Luyten, P., and Strathearn, L. (2011). Borderline personality disorder, mentalization, and the neurobiology of attachment. Infant Mental Health Journal, 32, 47-69.

Fonagy, P., Target, M., Gergely, G., Allen, J.G., and Bateman, A. W. (2003). The developmental roots of Borderline Personality Disorder in early attachment relationships: A theory and some evidence. Psychoanalytic Inquiry, 23, 412-459.

Herman, J.L., Perry, C., & van der Kolk, B.A. (1989). Childhood trauma in borderline personality disorder. American Journal of Psychiatry, 146, 490-495

Jellema, A. (2000). Insecure attachment states: Their relationship to borderline and narcissistic personality disorders and treatment processes in cognitive analytic therapy. Clinical Psychology and Psychotherapy, 7, 138-154.

Levy, K.N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. Development and Psychopathology, 17, p. 959-986 Zanarini, M. C., Williams, A. A., Lewis, R. E., Reich, R.B., R, B. R., & al, e. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *The American Journal of Psychiatry, 154*(8), 1101-6.	
	Dr. Childress Comment: Dr. Mercer is not an expert in anything.
	Q: Are you familiar with a book titled foundations and attachment based model of parental alienation?
	Dr. Childress Comment: Here is where they begin to weave their false world.
	A: Yes, I am.
	Q: And the author of that book is Dr. Craig Childress?
	A: Yes.
	Q: Have you read Dr. Childress' book?
	Dr. Childress Comment: Note in a little while where she testifies that she did not understand it.
	A: Yes, I have.
	Q: In the book has Dr. Childress describe what we might call a theory of parental alienation?
	A: Yes.
	Dr. Childress Comment: No. That is a false statement. I apply the established knowledge of professional psychology – I have no "theory" of "parental alienation." I describe pathology – the symptoms – by applying the scientifically established knowledge of professional psychology. That is false testimony. But see how they are going to deceive the court?
	Q: What is his theory of parental alienation as you understand it?
	Dr. Childress Comment: I have no theory of "parental alienation" – where is counsel? Why is she allowed to describe my thoughts and words. I can do that perfectly well for myself. She is distorting and mischaracterizing my work to suit her needs and that of minor's counsel. But it is false testimony.

	A: As I understand it, his idea is that there's a particular sequence of events which is going to begin in the childhood of one of the parents of the alienated child. That parent suffers from disorganized attachment, therefore, according to him they will become, they will develop a narcissistic personality disorder or borderline personality.
	Dr. Childress Comment: No, that is not true. I start with the symptoms. Diagnosis starts with the symptoms. What I do is explain how it is we see a specific set of symptoms by applying the standard and established knowledge of professional psychology. They are working from etiology forward, I am working from symptoms backward.
	A: Because they have developed this they will then enter onto a campaign of denigration of the other parent to the child with the intention of creating alienation of the child;
	Dr. Childress Comment: No, that is not true. That is in no way my contention.
	A: therefore, says Childress, if the child does not want to have contact with one of the parents this must be because they were alienated,
	Dr. Childress Comment: No, that is not true. That is in no way my contention.
	A: they were alienated because of the campaign of denigration,
	Dr. Childress Comment: No, that is not true. That is in no way my contention.
	A: the campaign of denigration occurred because of the personality disorder of the preferred parent,
	Dr. Childress Comment: No, that is not true. That is in no way my contention.
	A: the preferred parent has this personality disorder because of their early attachment history.
	Q: All right. That's a very nice summary. Thank you, Doctor. Now, I want to direct your attention, Doctor, is to what has been marked as minor's Exhibit 201.

	Dr. Childress Comment: But none of it is true. None of that response accurately conveys anything I am saying. That is false testimony provided to the court, misrepresenting what I say.
	A: 201?
	Q: 201.
	A: Okay. Okay. I have it.
	Q: And do you see in minor's Exhibit 201, have you seen this before?
	A: Yes.
	Q: And do you know what it is?
	A: Yes. It's quotations from this foundations book.
	Q: Quotations from Dr. Childress' book?
	A: Yes.
	Q: I don't want to go through these in the interest of time, each of them, but have you reviewed these quotes from Dr. Childress' books?
	A: Yes, I have.
	Q: Could you summarize for the court your understanding of what those quotes are, what they say, what the theme of them is?
	Dr. Childress Comment: Again, she will mischaracterize what I am saying. It will be false testimony. What she reports I say is not what I say.
	A: Well, the theme is, first of all, that a reluctance to visit one parent is caused by the actions of the preferred parent. The preferred parent is narcissistic or borderline personality and you can tell that because the child refuses to visit the other parent and that that personality disorder of the preferred parent stems from an early attachment problem.
	Dr. Childress Comment: No, that is not true. That is in not my contention.
	THE COURT: If I could stop for a moment, let me make sure I understand your understanding of **Dr. Childress' theory**, it's that the nonpreferred parent had disorganized attachment when he or she was a child; no?
	Dr. Childress Comment: See what they've done, they have the judge believing I have some sort of new "theory" = that is not true, I am merely applying the standard and established knowledge of professional

	psychology to a set of symptoms. That's called diagnosis. There is no "new theory" by Dr. Childress.\ It is Bowlby who links the "deactivation of attachment behavior" to "pathological mourning" it is both Bowlby and Kernberg who link disordered mourning to personality disorder pathology. None of this is Dr. Childress. But they are misrepresenting and mischaracterizing what I'm saying – what she is saying is false testimony, it is not true. The court is being given false testimony.
	THE WITNESS: The preferred parent.
	THE COURT: Oh, the preferred parent?
	THE WITNESS: Right.
	THE COURT: Had disorganized attachment which led to narcissistic personality which in turn leads to what you called a campaign of denigration against the nonpreferred parent?
	THE WITNESS: Uh-huh.
	Dr. Childress Comment: But your Honor, that's not true. That's not what I say. That is false testimony about what I say.
	THE COURT: Okay. Thank you.
	MR. MYERS Q: Now, I don't want to read all these quotes, Doctor, but I want to just direct your attention to a couple of them, this is in minor's 201, if you look at the second to the last quote from page 50 of Dr. Childress' book.
	A: Yes.
	Q: It says disorganized attachment in early childhood which in turn leads to the formation of narcissistic and/or borderline personality traits during later adolescence and early childhood, did I read that correctly?
	A: No. Early adulthood.
	Q: I'm sorry. Early adulthood. I didn't read it correctly. Thanks for correcting me. Am I correct in saying that Dr. Childress, correct me if I'm wrong, is saying that you can draw a correct direct causal connection between disorganized attachment in early childhood and the development in the adult of a narcissistic and borderline personality traits?
	Dr. Childress Comment: Rather than introduce what I actually say, minor's counsel filters my statements through the distorting lens of Dr. Mercer's falsehood.

	No, you've taken a limited set of words – they are out of context, the characterization you are making of my statements is wrong – it is false.
	A: That's what it appears to me that he's saying.
	Dr. Childress Comment: Dr. Mercer does not understand what I say. She lacks the professional knowledge base. She is not a clinical psychologist. She is outside of her boundaries of competence. She doesn't understand Foundations, she doesn't understand what I'm saying.
	Q: Is that statement that there's a direct causal relationship between a disorganized attachment and narcissistic borderline, is that a theme that runs throughout his book?
	Dr. Childress Comment: That question is not true – I do NOT assert that there is a direct causal relationship between disorganized attachment and narcissistic and borderline personality pathology. That is a false statement. See how they wove straw-man, and now they assign me to the straw-man argument. That is NOT what I have ever said. It is false testimony.
	A: Yes, it is.
	Your Honor, at this time I would offer minor's2 01 into evidence as minor's 201 I believe these are hearsay but I would organize that there admissible in that father's expert wrote the book that I am now referring to, if anything, it is an adoptive admission or an authorized admission under the Evidence Code.
	THE COURT: So these are quotes from Dr. Childress' books?
	MR. MYERS: They are, sir.
	THE COURT: So Ms. Mojaddidi, what's your response to the argument that it's an adoptive admission?
	MS. MOJADDIDI: Your Honor, so what I'm looking at is a 3 page document is that accurate.
	MR. MYERS: You're right, and I need to correct myself, I'm just referring to the first page.
	MS. MOJADDIDI: Okay. The first page, Your Honor, to the extent that they are exact quotes I don't have an objection.
	THE COURT: So I will admit 201.
	MR. MYERS: Well, is there any objection, Mr. Posner.
	MR. POSNER: No, but I was just curious why he was only offering page one.

	MR. MYERS: Well, Ms. Mojaddidi corrected me, Your Honor, I'm not offering pages 2 and 3 at this time, this are quotes in the literature the doctor already reviewed. I think you ruled on those.
	THE COURT: I will be admitting 201 but it's just the first page so MR. MYERS you'll need to make sure that the official copy, the last 2 pages are removed.
	MR. MYERS: Yes, Your Honor.
	MS. MOJADDIDI: Your Honor, could I just state that to the extent that they do accurately represent quotes so maybe I can compare it with his book because again this is the first time I'm seeing it but I'm assuming that it is accurate.
	THE COURT: Understood. I am admitting 201 as an adoptive admission on the assumption that it's an accurate representation of what Dr. Childress said, if that's not true let me know.
	MS. MOJADDIDI: Okay. And with your last statement Your Honor your only admitting page one.
	THE COURT: Correct.
	MS. MOJADDIDI: Okay. Thank you.
	MR. MYERS: Now, doctor, I want to direct your attention to minor's counsels Exhibit 2.
	THE COURT: Would that be 202.
	MR. MYERS: I'm sorry, I don't have the same numbers, I'm sorry, it's 202, Your Honor.
	A: Okay.
	MR. MYERS: And what is this.
	A: This is at least some pieces of his book of Dr. Childress' book.
	Q: All right. And I want to direction your attention to page 292 from the excerpt from Dr. Childress' book 292?
	A: Okay.
	Q: Did you find that?
	A: Yes.
	Q: And, Your Honor, I'm going to offer -- well, I won't. I assume the other side will offer it but it says on page 292 this is the chapter 9 that says diagnosis, it says diagnostic indicators and it says and I'll quote attachment based parental

	alienation can be reliably diagnosed by the presence in a child's symptom display of 3 characteristic and definitive diagnostic indicators. Have you read that before?
	A: Yes.
	Dr. Childress Comment: Pay attention, this is where the shell game begins.
	Q: Do you know what he means by these 3 characteristic and definitive diagnostic indicators?
	MS. MOJADDIDI: Objection, lacks foundation.
	THE COURT: Overruled. You can answer if you know.
	A: No, really, your guess is as good as mine what he means by most of this.
	Dr. Childress Comment: She is not a clinical psychologist. She has zero education, training, or background in the assessment, diagnosis, and treatment of pathology. She does not understand clinical psychology. She is not a clinical psychologist. She is practicing beyond the boundaries of her competence. She does not understand what I'm talking about. She is not a clinical psychologist. She has never – in her life – assessed any pathology, diagnosed any pathology, or treated any pathology – she has no clue… "your guess is as good as mine what he means by most of this." Can it be more clear. She is not a clinical psychologist and she is opining on things concerning assessment, diagnosis, and treatment of pathology that she knows NOTHING about. She is not a clinical psychologist. Can we be clear on what that means? She knows nothing about the assessment, diagnosis, and treatment of any pathology – anything.
	MR. MYERS: But you have read it?
	A: I've read it.
	Q: And are you saying you're having difficulty figuring out what he means?
	A: Yes.
	Dr. Childress Comment: She's not a clinical psychologist. Remember where she thinks it's hard to describe the attachment system, and calls it a "control" mechanism? She can't track the constructs. You'll see that again shortly. She's not very smart, she doesn't know a lot of

	stuff, but she thinks she doesn't need to know it, because she makes up whatever she wants reality to be.
	Q: Now, but you have read it and tried to understand it; is that right?
	A: I've read it. The problem is the way he uses certain words which, for example, he speaks of attachment bonding, bonding has nothing to do technically with how children feel. Bonding refers to adult attitudes towards children.
	Dr. Childress Comment: Listen to how Mary Ainsworth describes the attachment system, and then compare that to what Jean Mercer says about bonding not being related to the attachment system. She can't grasp concepts.
Ainsworth, M.D.S. (1989). Attachments beyond infancy. American Psychologist, 44, 709-716. "I define an "affectional **bond**" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional **bond**, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711) "An "attachment" is an affectional **bond**, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional **bonds**, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (p. 711)	
	Dr. Childress Comment: "Bonding refers to adult attitudes toward children." What? That is a bizarre statement. Bonding refers to both parent bonds to the child and the child's… attachment bonds… to the parent. But Dr. Childress "uses certain words" that she can't understand.
	A: Also, when he talks about suppression of the motivations, I think he means that the behavior he wants is not there. How he would know whether the motivation was suppressed, I don't know.
	Dr. Childress Comment: No. The attachment system is a primary motivational system of the brain, like eating or sex. It is a neurologically embedded primary motivational system of the brain.

	We can suppress our motivation for eating, for example. But if we go too far we're into the pathology of anorexia. The attachment system is a primary motivational system of the brain. Did you know that Dr. Mercer? It is. So when I talk about the child suppressing their attachment bonding motivations, I'm talking about the child over-riding their normal impulses to bond to the parent – they are suppressing those motivations. Bowlby calls it the "deactivation of attachment behavior," I referred to it as the suppression of attachment behavior. Again, this points out that she doesn't know clinical psychology, and she doesn't comprehend what I'm saying. Frankly, she doesn't seem very smart.
	Q: In your opinion to a reasonable degree of scientific certainty, does the professional community of mental health professionals including psychologists generally accept Dr. Childress' attachment based parental alienation syndrome as a wrapped reliable and valid theory?
	Dr. Childress Comment: How would she know? She's not a clinical psychologist, never has been, and she's been retired from her teaching post since 2006. She has no basis for any opinion.
	A: No, they do not.
	Dr. Childress Comment: Yes, they do. We disagree. How do we resolve the disagreement? Let's ask everyone, Do you agree with Dr. Childress. Because, in truth, all Dr. Childress is saying is what Bowlby, and Minuchin, and Beck, and Kernberg, and Millon… say. I have direct quotes and citations for ever word and sentence I say. None of this is me saying it, it's Bowlby, Minuchin, Beck saying it. So let's ask the community of professional psychology if they accept Bowlby, Minuchin, and Beck (attachment, family systems therapy, personality disorders) as "reliable and valid theories." What do you think, community of professional psychology, are attachment, family systems therapy, and personality disorders "reliable and valid theories"?
	Q: And I would ask you to elaborate on why you say no, they do not?
	A: Well, first of all, I don't think that most psychologists have ever heard of this, and second, if they have heard of it and they've read it and they know anything about how attachment functions it couldn't possibly accept this as legitimate, you know, we've got

	decades of theory and research about this and none of this fits into it or is congruent with it.
	Dr. Childress Comment: She's just making stuff up.
	Q: Well, what doesn't fit?
	A: Well, it's not plausible to talk about, first of all, suppressing a system. It makes perfect sense to talk about suppressing a behavior. If I tell a child don't do that anymore, you know, I may be succeeding in suppressing a behavior, but if we're talking about a system which is part of the functioning of personality and cognition, how that can be suppressed, that doesn't make any sense, and if it were suppressed how can you unsuppress it. This would be like saying the person didn't remember what I said because I had suppressed his memory capacity.
	Dr. Childress Comment: I'll try to go slowly for you, Dr. Mercer. The attachment system is a motivational system. It motivates us to do things. Like the eating system. You know how hunger motivates us to eat? Like that, a motivational system. Now think about this carefully, can you suppress your motivation to eat food? Like on a diet or something? You're hungry, but you don't eat. That's suppressing a primary motivational system. How do you unsuppress it? You eat. Seriously. She's not qualified to be critiquing something she doesn't understand – and we're just talking the attachment system – remember, she knows NOTHING whatsoever about any aspect of clinical psychology, assessment, diagnosis, and treatment. Nothing.
	Q: In your opinion to a reasonable degree of scientific certainty, does the professional community of mental health professionals including psychologists generally accept Childress' attachment based parental alienation as their reliable and diagnostic tool?
	Dr. Childress Comment: She has no grounds to form an opinion.
	A: No
	Dr. Childress Comment: Yes they do**.**
	Q: And can you elaborate on why that is your opinion?
	A: Well, for example, when Dr. Childress and his colleague presented at the conference of the American Federation -- no, Association of Family and Conciliation Courts, a discussion about their diagnostic approach after a complaint in which I participated to the American Psychological Association, the continuing education credits that had been

	offered for that presentation were canceled and the AFCC was told never to allow these people to present for APA continuing education credits again. That's it's not approved of.
	Dr. Childress Comment: I had heard rumors after the fact, I was never clear on what happened because I was never contacted by the AFCC. It makes sense now. Dorcy Pruter, my co-presenter, doesn't have a doctoral degree. Apparently, there's something in the CE requirements that all presenters must have a doctorate degree. So it appears that Dr. Mercer and some of her friends complained to the AFCC about Dorcy presenting and the recipients receiving Continuing Education credits for our seminar because Dorcy doesn't have a doctorate degree. So apparently, the AFCC rescinded all the CE credits for everyone who attended the seminar because Dorcy doesn't have a doctorate degree. I have a doctorate degree, but apparently for CE credits all presenters must have a doctorate degree. So it's all a technicality about CE credits. It has nothing to do with approving or disapproving of a diagnostic model. But Dr. Mercer is trying to twist reality to her distorted perception. The AFCC response to her complaint was a technical issue, not a substantive one. The AFCC doesn't "approve" or "ban" content. They probably won't allow CE credits for a Dorcy involved seminar. That's their loss, she has highly valuable information. Our Powerpoint for that presentation to the AFCC is up on my website, people can go look for themselves what we talked about. I was basically saying we need to apply the standard and established knowledge of professional psychology, and urging my professional colleagues toward ethical professional practice. Then we described how the High Road workshop achieves it's effectiveness. I'm sorry the people that heard us has they CE credits revoked because Dorcy doesn't have a doctorate degree. Still, it was useful information for them.
	Q: When you say these people, who are you referring to?
	A: Childress and Dorcy Pruter.
	Q: Who is Dorcy Pruter?
	A: Dorcy Pruter is a woman who is a life coach, she works with Childress, and she is the person who runs the program that he refers people to for treatment.

	Dr. Childress Comment: That's not true. A lot of it is, Dorcy is a life coach, she is a colleague and we work on different aspects of shared cases sometimes, I have collaborated with her, and I do refer to the High Road protocol The part that's not true is that the High Road workshop is some form of treatment. It's not. That's false. The court is again being presented with false information. Dr. Mercer has NEVER reviewed the High Road protocol. I have. Dr. Mercer has never seen the High Road workshop being conducted across multiple days. I have. Dr. Mercer has never received for treatment a parent-child relationship recovered by the High Road protocol. I have. The High Road workshop of Dorcy Pruter represents evidence-based practice. And it's not therapy. It's a workshop. They watch educational videos, they do structured workshop activities on communication and problem-solving. Dorcy can explain it all. We did that, at the AFCC convention. We'd be happy to do that again. We can explain exactly how it achieves its effectiveness. But Dr. Mercer knows nothing about the High Road workshop. She's never seen the protocol, and she's never seen it being conducted. Plus, she's not a clinical psychologist, so she's not really in a position to evaluate it anyway. I am a clinical psychologist. I have seen the protocol. I have seen it being enacted across several days. I have received a parent-child relationship that had been recovered by the High Road workshop. I have a foundation for my opinions. Dr. Mercer doesn't.
	Q: In your opinion to a reasonable degree of scientific certainty, does the professional community of mental health professionals including psychologists generally accept Dr. Childress' recommended treatment as reliable and valid?
	A: No, and there's no evidence basis to support the use of the treatment.
	Dr. Childress Comment: Yes, they do. Family systems therapy is one of the four schools of psychotherapy (psychoanalytic, humanistic-existential, cognitive-behavioral). Family systems therapy (Minuchin, Bowen, Haley, Madanes, Satir…) is the appropriate model of psychotherapy to apply to family pathology.

	And… Dr. Mercer is not a clinical psychologist, yet she is opining on matters of treatment – i.e., clinical psychology. She is practicing beyond the boundaries of her competence – AND – she is giving false testimony to the court in the process.
	Q: What is the treatment that you're referring to?
	A: The treatment that is managed by Dorcy Pruter is called High Road and it is a program which involves two parts, one is that the child be completely separated from the preferred parent for some period of time usually up to I think about 9 months, during that period of time the child is allowed to earn contact with the preferred parent after a number of weeks by cooperating with the nonpreferred parent.
	Dr. Childress Comment: That's not true. First, it's not a treatment. Second, you have no idea what it is because you've never seen either the protocol or the workshop. Third, that's not what happens. You have things all scrambled in your brain. That's not what happens. That's not true. That is false, it is false testimony offered to the court by ignorance.
	A: The program itself, specifically the treatment program as I understand it is a 4-day program in which the child is taken to a place I believe somewhere in California and during the period of time that they're there they are asked to watch videos and to play games and to have discussions with the nonpreferred parent. They are told as I am told by people who have been through this program that they may leave if they want to, they don't have to do this, on the other hand, they are in a place that they don't know anything about, their phones and money have been taken away from them, they're not in any position to leave if they did definitely want to. They're also taken there in many cases by youth transport service workers and some have been taken there in handcuffs.
	Dr. Childress Comment: What Dr. Mercer says is not true. It has enough resemblance to reality to require an extended period to dissect. First, it's not a treatment. It is a 4-day workshop. The family can travel to Dorcy in California, Dorcy can also travel to the family. They do watch educational videos, they don't play "games" – they're structured communication and problem-solving workshops, relationship building exercises, and they probably seem fun to the children. "They are told that they may leave." The child is participating in the High Road workshop by court order. I suppose the child could defy the court order and leave. But it would be in defiance of a court order for their participation. Typically, the court order relies on a confirmed DSM=5 diagnosis of child abuse relative to the parenting of the allied and supposedly "favored" parent. Enrollment in the High Road workshop is by court order.

	Yes, sometimes the youth are transported by Youth Transport services, because they are so defiant of court authority that it takes an escort for them to comply with court orders. Once they arrive, however, they have the best four days. The first two hours or so, they might remain in a grumpy huff, but my mid-day they are participating actively. Dorcy collects rating twice daily on three relationship qualities, Affection, Cooperation, and Social Involvement. She collects these ratings for every child enrolled in the High Road, throughout the workshop period. The data indicates that the child skyrockets to highly bonded, highly cooperative, and highly socially engaged across the days. So the children typically are sad when the workshop comes to a close, they were enjoying it. That is the truth. I have seen the protocol, I have watched the recovery workshop, I have received a recovered parent-child relationship into my private practice. Unlike Dr. Mercer, I have a foundation for my opinion. And it's not therapy. There is not a therapy on the planet that can recover the child's authenticity and the parent-child bond in a matter of days. It is gentle, it is effective.
	Q: Now, I would direct your attention in minor's 202, the excerpt from Dr. Childress' book to page 292, we referred to this a little bit, but he writes on 292 attachment based parental alienation syndrome
	Dr. Childress Comment: Notice how minor's counsel links my work to Parental Alienation Syndrome, the work of Richard Gardner. I disavow and repudiate the constructs of "parental alienation" and "Parental Alienation Syndrome" as beneath professional standards of practice… and look how minor's counsel links my to PAS in the question. The minor's counsel is presenting false and misleading information to the court. That's a fact. Is he doing it intentionally? Is his intent relevant? I will allow others to decide on the scope of role for minor's counsel in presenting evidence to the court. Is misleading the court with false information acceptable standard of practice for the role of minor's counsel?
	can be reliably diagnosed by the presence in the child's symptom display of three characteristics. The first diagnostic indicator is complete suppression of the child's attachment bonding motivations toward the normal range affectionately available parent. Now, tell me again, do you believe that that's an accurate statement that there can be complete suppression of the child's attachment bonding system?

	Dr. Childress Comment: A complete suppression of the child's motivation to bond to the parent – the child does NOT want to bond to the parent.
	A: I don't even know what an attachment bonding system is. I assume that he means the attachment control system as discussed by Bowlby, you know, the use of attachment and bonding together like that is really to me indicative of an amateur approach to this.

Ainsworth, M.D.S. (1989). Attachments beyond infancy. American Psychologist, 44, 709-716.

"I define an "affectional **bond**" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional **bond**, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711)

"An "attachment" is an affectional **bond**, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional **bonds**, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (p. 711)

	Dr. Childress Comment: Seriously, she does not know what she's talking about. She has some of the simple stuff okay, but then she veers off. Bowlby doesn't talk about a "control system." She's not grasping the concept of what the attachment system is. Remember – she has NEVER worked with any form of attachment pathology ever. It's a predator-created system. Children bond to parents so they receive protection from predators. It goes back across species, it's called imprinting in other species. In humans, that bonding system is more complex because we're more complex. But it's the same ground brain system – baby zebra stays close to mommy zebra, baby ducks follow mommy ducks. Bowlby spent much of the first volume on Attachment linking our attachment system to an evolutionary line and the work of Konrad Lorenz. It's a predator-driven system. Dr. Mercer thinks it's some sort of control system. It's a motivational system. A primary motivational system of the brain, evolved through the selective predation of children. Children are motivated to bond to their parents. That's the attachment system. She doesn't know what she's talking about she is just making stuff up. Except the part about that she doesn't understand what I'm saying, I bet that's true, I'll bet she doesn't understand. She's not a clinical psychologist.

	A: People who are seriously involved with this topic do not talk about attachment and bonding together because bonding is something quite different.
	Dr. Childress Comment: Seriously. Read the quote by Mary Ainsworth. Jean Mercer is clueless. Absolutely clueless. She is not an expert in anything. She is testifying as an expert in violation of California state law. She is representing herself to the court as a "psychologist" when she's not, as defined by California state law. Multiple times she violated the APA ethics code regarding practice beyond the boundaries of competence – and in each instance the information she provided to the court was wrong – it was false information. She and minor's counsel are presenting false information to the court. Read Mary Ainsworth's quote, read Dr. Mercer's statement. Dr. Mercer does not know what she is talking about, she is not an expert in anything..
	A: Again, as for suppressing is the motivations, it seems to me that the simple statement that says here's the original problem, the child does not want to have contact with the nonpreferred parent. If we reinterpret this to put in some extra obscuring words like suppression of the motivations and so on, then we end up with this gobbledygook.
	Q: Now, directing your attention to page 293, the last paragraph says, and I won't read the whole thing, the presence in a child's symptom display of this specific set of 3 diagnostic indicators represents definitive clinical evidence for the presence of pathogenic parenting by the allied and supposedly favored parent associated with an attachment based model for the construct of parent alienation. No other psychological or interpersonal process besides an attachment based model of parental alienation can result in this specific set of 3 diagnostic indicators in a child's symptom display. As far as you are concerned, is that an accurate statement?
	Dr. Childress Comment: First, note how diagnosis works back from the symptoms, diagnosis is symptom-driven. We have a set of symptoms, explain them. Second, Dr. Mercer is not a clinical psychologist. She has no background training, education, or experience in diagnosing pathology. It is outside of her boundaries of competence.
	A: Well, it's the same thing I was saying before, if you go back over all these things that he's talking about, all they boil down to is the child doesn't want contact with the nonpreferred parent. There's just a variety of different ways of explaining or elaborating on that point, so as for it being pathogenic parenting that's involved here, you know, the two things don't necessarily have anything to do with each other.

	Dr. Childress Comment: In that statement, Dr. Mercer is practicing clinical psychology without a license, and without any background education or training. She is determining what symptoms go together and which ones don't. That's the purview of clinical psychology, the assessment, diagnosis, and treatment of pathology. You need to be licensed to do that. You need to have a degree in clinical psychology – not experimental psychology, clinical psychology – to do that. You need a year of supervised pre-doctoral internship and a year of supervised post-doctoral fellowship before you become eligible to sit for the licensing examination. Dr. Mercer has done none of that. Yet she opines on diagnosis of pathology. She has never assessed, diagnosed, or treated anything in her life..
A: It's my understanding that in evaluations of this kind there's supposed to be development of some alternative hypothesis why something is happening and then there is a comparison of the observed defense with those hypothesis in order to confirm or disconfirm one or another. I don't see in this if there are any alternative hypothesis offered at all.	
	Dr. Childress Comment: It's your understanding, Dr. Mercer? Your understanding from where? Do you have a doctorate in clinical psychology? No. Do you have any internship training in clinical psychology? No. Do you have any experience assessing, diagnosing, or treating any pathology? No. So where does this "understanding" of clinical psychology come from? Let me move slowly here, Dr. Mercer. That "alternative hypothesis" thing is called differential diagnosis, and yes, we consider all the possible alternatives. So here it is with the three diagnostic indicators. If those symptoms are present – see how we always start with the symptoms, not the etiology – if those symptoms are present, what's the explanation. The explanation is called our diagnosis. So let's put all of the possible explanations on the table. I take this one – this AB-PA model one. You can have all the rest. All of the other possible explanations, they belong to you. Now, I'm going to explain the symptoms using Bowlby, Minuchin, Beck. You have all the other possible explanations to try to come up with an alternative one. I can't. Because there is none.

	But if you don't believe me, you try it. You have all the other alternative hypotheses… you explain how we see those three specific symptoms in a child. We work from the symptom back. You're not a clinical psychologist, I am. I've worked with ADHD, autism-spectrum, school-based problems, Oppositional Defiant Disorder, juvenile justice problems, complex trauma and child abuse. There is no other pathology in all of mental health that will produce that set of symptoms. Try it. Try to come up with an explanation for that set of three symptoms. You won't be able to do it. Because there is no other explanation. Try it.
	Q: So if he finds these 3 things in a child he says he can definitive diagnose attachment related parental alienation?
	A: Well, this is how he defines it, I mean, this is all proof by assertion basically.
	Dr. Childress Comment: No, you try it. Come up with an alternative explanation for that set of three symptom.
	Q: Do you agree with his assertion?
	Dr. Childress Comment: She is not a clinical psychologist. We are talking about diagnosis – that's clinical psychology. I am a clinical psychologist. That's like asking the plumber if they agree with Stephen Hawking's equations on black holes. They may have an opinion, but it has no value. She's not a clinical psychologist.
	A: I don't see any evidence for it. It just seems to me that this is simply restating particular facts again and again and then coming out with a conclusion that, you know, is made to appear to be based on them, but when you look at it there's no possible connection.
	Dr. Childress Comment: She doesn't understand. She's confused. She's not a clinical psychologist, she's out of her league, she can't track the concepts.
	Q: Your Honor, at this point I would like to hand the to witnesses an additional document. It's Dr. Childress' deposition in this matter.
	THE COURT: You may.
	MR. MYERS: I just have a couple of questions about it.
	THE COURT: Does Ms. Mojaddidi have a copy of this?

	MS. MOJADDIDI: Thanks.
	MR. POSNER: Oh, you have an extra. All right. That will be easier.
	MR. MYERS Q: Now, have you read this deposition, Doctor?
	A: Yes, I have.
	Q: I don't want to go through the whole thing with you, but I will represent to the court that this document is a transcript of the deposition given by Craig Childress on June 13th of this year in the matter of parent against parent in the office of Mr. Posner and all three of the present attorneys were present, the new minor's counsel was not present, she had not been yet appointed.
	MR. POSNER: So the court's aware, I do have the sealed original.
	THE COURT: It should be lodged with the court. Do you have it with you today?
	MR. POSNER: Yes.
	THE COURT: Please hand it to the bailiff.
	Q: Thank you, Mr. Posner.
	MS. MOJADDIDI: Just, Your Honor, for clarity, it's the sealed copy, to the extent it will be moved into evidence will be that copy correct because this one is marked up with a lot of notes.
	THE COURT: Right. My understanding of the rules is that the sealed deposition should be lodged and so it will be.
	MS. MOJADDIDI: Okay. Thank you.
	MR. MYERS: I just want to get your help a little bit, Doctor, in a couple of places in this deposition. Will would you turn to page 33?
	A: Okay.
	Q: Now, I will represent to the court that this is Mr. Posner asking a question of Dr. Childress, the question is, if the children, and this is hypothetical, are strongly bonded to the mother and not strongly bonded to the father and the father causes them to be taken away from the mother, what are the potential effects on the children. So that's the question. Now, the answer that Dr. Childress gives is the question becomes why the children are not strongly bonded to the father, their father, the children, the attachment system bonds to parents and so the question would become why aren't the children strongly bonded to their father as well, and then it gets into a larger dynamic and family systems therapy that you begin to look for triangulations of children into the spousal conflict and so it begins to expand out as to the reasons for the family conflict into family

	systems therapy and the constructs of family systems therapy. Does that answer make sense to you?
	Dr. Childress Comment: Notice the form of the deposition question, what if we remove a child from a supposedly bonded parent to provide greater contact and involvement with the other parent, what are the effects on the child? That depends on what family dynamics are involved. Are there any triangles and coaltions? That's family systems therapy. But watch, Dr. Mercer is not a clinical psychologist, she's a teacher of basic ed psychology courses at a small college a decade ago. She knows zero about actual therapy – so nothing at all about family systems therapy. Listen to her response.
	A: It does not answer the question that was asked, no.
	Dr. Childress Comment: Yes I did. The answer is that the effects on the child depend on the family context, are there any triangles and coaltions?
	Q: You're a psychologist, he's a psychologist, does it make any psychological sense even if it isn't a direct answer to the question?
	Dr. Childress Comment: That's not true. She is not a psychologist. The term psychologist is a protected term by California state law. It is reserved ONLY for licensed clinical psychologist. Only licensed clinical psychologists are allowed to call ourselves psychologists. What's Dr. Mercer? She's an instructor. She's a teacher. She's a professor. But she is NOT a psychologist. By law.

Relevant California Statutes

California Business and Professions Code BPC § 2902

(c) A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychology consultation," "psychology consultant," "psychometry," "psychometrics" or "psychometrist," "psychotherapy," "psychotherapist," "psychoanalysis," or "psychoanalyst," or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology.

California Business and Professions Code BPC § 2903

(a) No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding,

predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.	
	A: It makes psychological sense in that he is attempting to answer something that he's apparently not prepared to answer.
	Dr. Childress Comment: She's not a clinical psychologist. She doesn't understand ideas from clinical psychology. She has to training or background in family systems therapy – in any aspect of clinical psychology. She's confused and disoriented because she's ignorant about clinical psychology, and about the constructs and principles of clinical psychology. Ten years ago she taught general ed psychology courses at a college. She's beyond the boundaries of her competence. Question: Why does an experimental psychologist, with no education, training, or experience ever in clinical psychology, join the clinical psychology division of APA? Wannabe. She wants to be a clinical psychologist. But she's not. Once you see who she is, a teacher, many years ago, seeking to retain meaning and relevance. She always wanted to help children. Why? Counter-transference. She's found someone who values her opinion. She's actually a tragic figure, once you see. She's not a clinical psychologist, yet look how she opines on things she knows nothing about. Attachment doesn't involve bonding, and Mary Ainsworth clearly indicates that, yes it does. What minor's counsel is doing is exploiting an aging confused person, who has a Ph.D. degree from her days of teaching college. He has an agenda, and he's using her to reach it. It was a straw-man display of false and misleading testimony presented to the court.
	Q: We see something which seems to me to be similar on page 38 where Mr. Posner asks another question which is, the question is, if, in fact, while they were in the 50/50 custody and their mother and father they became potentially suicidal and after they stopped seeing their father that that potential suicidality tendency was resolved, how would you view that, and Dr. Childress says in answer, there's a potential, there's a number of differential diagnoses that emerge with suicidality or suicidal ideation, one zone is authentic suicidality and we want to look at its association to sex abuse, and he goes on and on from line 6 to line 20. Can you make anything out of his answer?

	Dr. Childress Comment: Again, my response from the deposition is from clinical psychology, looking at all those "alternative hypotheses" that Dr. Mercer was talking about a few minutes ago – differential diagnoses.
	A: Well, he's simply picking up on one particular word that was used and expanding on that, but it's very nonlinear. He's not attempting to answer the question which I believe meant would you conclude that the original custody situation had been one of the possible causes of suicidality.
	Dr. Childress Comment: That's one possibility, Dr. Mercer. What about the other alternative hypotheses. Nonlinear? I expect you find it that way because you have no educational background or training in any form of pathology, so you really don't understand what's linear and connected and what's not.
	Q: Now, I won't do any more examples, perhaps you made the point. When you look at this deposition and see his answers sometimes they're quite responsive to the questions, aren't they?
	Dr. Childress Comment: All of my answers were responsive. Sometimes they may not have been responses that were desired.
	A: Yes.
	Q: But did you see on the two occasions and perhaps others where he just seems to refuse to answer the question and descends into what I would call psychobabble?
	Dr. Childress Comment: This is a false and misleading characterization presented by minor's counsel to the court. If you want to ask me the question again in my testimony, please do. But it is not "psychobabble" it is professional terminology. Why is it your intent to demean? You are minor's counsel, what is your role relative to testimony presented to the court?
	MS. MOJADDIDI: Objection, leading.
	MR. MYERS: She's an expert, I can lead an expert.
	THE COURT: The parties are allowed to lead experts and I'll allow it.
	Dr. Childress Comment: What Dr. Mercer may find out relative to her violation of California state law and the APA ethics code is that attorneys are allowed to lead the expert witness, but that doesn't mean the expert should go there. It may not be minor's counsel who faces consequences for violation of California state law and the APA ethics code.

	MS. MOJADDIDI: Objection, argumentative.
	THE COURT: Well, I'll leave it to Dr. Mercer whether to adopt that term or not.
	A: I prefer my other gobbledygook term.
	Dr. Childress Comment: She doesn't understand. She's not very bright, she has difficulty with complex concepts. How old is she? She retired in 2006? She may not be comprehending things as well as she once did. And, she never did comprehend any of this, because she was never educated or trained as a clinical psychologist. The store clerk may find Stephen Hawking's equations to be challenging to understand too.
	MR. MYERS: All right. We'll use your term, Doctor. I want to ask you just two questions and then I'll be finished, Doctor, and this is a bit off of what the theme that we've been developing, but are you familiar in your experience reading the psychological literature with the concept of reunification therapy?
	Dr. Childress Comment: Or your term, Mr. Myers? Psychobabble or gobbledygook. That's not true, it's neither. It is the application of the established knowledge of professional psychology – and clinical psychology. Why would you seek to demean a licensed clinical psychologist with such derisive slander? What is the role of the minor's counsel relative to presenting evidence to the court. Are you supposed to take sides in the spousal conflict? If the children are in a cross-generational coalition, what do you do? Do you support their healthy bonding to both parents, or do you collude with the cross-generational coalition? What is the role of minor's counsel? Why would you seek to demean with slander. The evidence you presented to the court was not true.
	A: Yes.
	Q: Is there such a thing as reunification therapy?
	Dr. Childress Comment: Again, Dr. Mercer is NOT a clinical psychologist, she is not qualified to render an opinion on therapy – any form of therapy. Yet still, watch her answer. The truth is, "No, there is no such thing as reunification therapy, there is no theorist, no book, or journal article that provides any model for any form of therapy called "reunification therapy" – it doesn't exist. Watch what Dr. Mercer says.

	A: The term reunification therapy is used for a wide variety of attempts that are made to improve communications between children and divorced parents where the child is having difficulty with one of the parents, reluctant to see the parent, whatever it may be, and sometimes that's pursued just in an ordinary talk therapy kind of way, sometimes with more of a family systems approach where everybody is present and talks about things, but the term reunification therapy is also sometimes used to refer to what I would call intensive parental alienation treatments, High Roads would be one of those. There's a program called Family Bridges. These are all programs in which it's not just, you know, you go once a week and talk things over in the office, but instead the child goes away to a camp or, you know, some sort of residential setting along with the nonpreferred parent and the contact with the preferred parent is prohibited.
	Dr. Childress Comment: See how she defines it so vaguely that it could by anything done by anybody? There is no book written or theorist who has described anything called "reunification therapy." But then she suddenly jumps over to her non-orthodox treatments. It's odd that she could be an "expert" in non-orthodox treatments but have zero education, training, and background in all of the normal forms of psychotherapy. She's not a clinical psychologist. What makes her an "expert" in any form of therapy? She does. Didn't you hear her tell us in voir dire, that she's an expert in un-orthodox forms of therapy. An expert in her own mind. She has never – never – been trained in ANY form of psychotherapy, and she has never conducted even a minute of psychotherapy ever. And she's an expert in therapies. Okay.
	Q: But some of these -- you're an expert on orthodox treatments?
	A: Right.
	Dr. Childress Comment: See, she tells us, right there, that she's an expert in therapies – even though she not a clinical psychologist, never has been, never had any education or training in any form of therapy – but she says so, so she must be an "expert" right?
	Q: Some reunification therapy you would characterize as legitimate mainstream efforts to help families, is it not?
	Yes.
	Dr. Childress Comment: And the universe appointed her the high-arbiter of therapy… when? Can I see the documentation that elevated her to the position of judging therapies as legitimate or not. Does she have some sort of government card that allows her to do that, do decide on the

	legitimacy of therapies – especially since she's not a clinical psychologist and knows absolutely nothing about therapy.
	Q: And do you think that's generally accepted among psychologists?
	A: Yes. Now, whether they are effective or not is another question, but yes, I think they are considered the way you do things.
	Dr. Childress Comment: Opining about therapy. Another, yet again, violation of Standard 2.01a practice beyond the boundaries of competence. Would the minor's counsel be considered in collusion with Dr. Mercer's violation of Standard 2.01a and in using her violations and ignorance to present false evidence to the court?
	Q: Three more questions then, Doctor, are you simply biased against Dr. Childress?
	A: I am biased against people who take the very important concepts of attachment theory and attempt to weave them into something that they were never intended to do.
	Dr. Childress Comment: I'll take that as a yes then… "I am biased…" Again, who appointed her to be the guardian of "very important concepts" and deciding what they are "intended" and not intended to do. Such as when a clinical psychologist applies the concepts to diagnose and treat pathology – they weren't "intended" for that – according to Dr. Mercer, who is the self-appointed guardian of such things.
	Q: Do you believe that's what happened with Dr. Childress?
	A: Yes, I do think so.
	Dr. Childress Comment: She is an aging pathetic figure. What minor's counsel is doing to exploit her is of distasteful. I'll let others decide on the scope and role of minor's counsel in presenting evidence to the court.
	Q: Would you characterize Dr. Childress' treatment recommendation of removing the children from the preferred parent for 9 months with no contact between the preferred parent and the children as an unorthodox treatment?
	Dr. Childress Comment: Another opining on treatment, again in violation of Standard 2.01a of the APA ethic code.
	A: Yes, very much so.

	Dr. Childress Comment: The only justification for removing or restricting a parent's contact and involvement with a child is a DSM-5 diagnosis of Child Psychological Abuse. I do NOT advocate for removing a child without a corresponding DSM-5 diagnosis of child abuse. If, however, there is a DSM-5 diagnosis of child abuse made by a mental health professional, then the standard of practice and professional duty to protect requires the child's protective separation from the abusive parent. That… is my position. Minor's counsel distorted my position to mislead the court. My position is clear and has always been clear. The ONLY justification for removing a child from a parent's care is a DSM-5 diagnosis of child abuse. So then, according to Dr. Mercer, protectively separating a child from an abusive parent – who has been given a DSM-5 diagnosis of child abuse made by a mental health professional – is unorthodox treatment. No, it's professional standard of practice.
	Q: Do you know of any evidence which would support the utilization of such a treatment?
	Dr. Childress Comment: Again – to be clear – the treatment we're talking about is protectively separating a child from a diagnosed abusive parent. Is there any evidence that support separating a child from a diagnosed abusive parent. Yes. Pretty much everything in the child abuse literatue says that we should protectively separate children from abusive parents. The ONLY justification for separating a child from a parent is child abuse, and child abuse should be accompanied by a DSM-5 diagnosis of child abuse. Yes, there is lots and lots of support for separating children from abusive parents.
	A: No.
	Dr. Childress Comment: So Dr. Mercer is arguing that we should not separate children from abusive parents – parent who have been diagnosed as abusive of the child – we should not protectively separate these children from the abusive parent.
	Q: Are you being compensated for your time today?
	A: No.

	Q: Did you pay for your own ticket to get here?
	A: Yes, I did.
	Dr. Childress Comment: Why?
	Q: Why have you gone to so much trouble to come all the way from New Jersey to share your information with this court?
	A: I'm really concerned about the way some of these attachment concepts are being misused and the way that it's possible for people that I know are very disturbed and even desperate about their family situations to be essentially sold a bill of goods by somebody who offers what appears superficially to the layperson to be a reasonable explanation of what's going on and offers hope to that person and charges them a considerable amount for it. My understanding is that the High Road program costs about $20,000 for the 4 days of, what do we call it, experience, I won't call it treatment, and it really disturbs me to see my profession being used in this way.
	Dr. Childress Comment: She's the self-appointed guardian of "attachment" – she gets to decide how the constructs are used and by whom. "My profession." She's not a clinical psychologist. She never was, she neer has been, she has never assessed, diagnosed, or treated any pathology in her entire life – yet it's "my profession."
	Q: Is it your -- well, I'll just ask you the question, do you think that Dr. Childress' book and his methodology evaluating children is possibly harmful to children?
	A: I think it's potentially harmful, yes.
	Dr. Childress Comment: And you are qualified to judge the work of a licensed clinical psychologist because…?
	MR. MYERS: Thank you, no further questions, Your Honor.
	Dr. Childress Comment: Remember all that testimony about infant attachment and the Strange Situation? Where did that go? Nowhere. It went nowhere. Minor's counsel held out Dr. Mercer as an expert in psychology, in violation of California state law.
Relevant California Statutes	
California Business and Professions Code BPC § 2902 (c) A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words	

"psychology," "psychological," "psychologist," "psychology consultation," "psychology consultant," "psychometry," "psychometrics" or "psychometrist," "psychotherapy," "psychotherapist," "psychoanalysis," or "psychoanalyst," or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology.

California Business and Professions Code BPC § 2903

(a) No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.

Dr. Childress Comment: The statues seem pretty clear to me. Dr. Mercer is not licensed, she is not allowed to represent herself as a "psychologist" which she did in her testimony – in violation of California law and in fraudulent misrepresentation to the court. Was minor's counsel complicit in presenting fraudulent testimony to the court?

She was offered to the court as "an expert in the field of psychology" that's one of the definitions of acting as a psychologist – and BPC § 2903, "No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter."

To the extent that her ignorance of clinical psychology was exploited by minor's counsel to introduce false and misleading evidence to the court, is minor's counsel complicit in presenting false and misleading testimony to the court.

What is the scope and role of minor's counsel relative to testimony presented to the court"

	THE COURT: Okay. Well, let me take argument on that issue. It looks like there are a number of these articles and so the suggestion is that Sanchez doesn't apply because none of this is case specific.
	Ms. Mojaddidi, comments, argument on that?
	MS. MOJADDIDI: Your Honor, I think my understanding about how Sanchez should be interpreted that while an expert may testify that she may have relayed on -- I'm sorry, relied on something that could be hearsay and otherwise inadmissible that she cannot relay the information to the court and that's to the extent that she simply relied upon it. I understand experts rely on all types of things, but to actually relay it and to ask for hearsay to be admitted into evidence I think is exactly what Sanchez provides.
	THE COURT: Well, it seems it does draw a line in case specific and non-case specific facts and that line is not always clear. I haven't read these articles but I don't imagine they say anything about the parties here, but Mr. Myers, if it's not offered -- Sanchez also teaches us that these would be considered for the truth I believe.
	MR. MYERS: Case specific would be considered for the truth, Your Honor.
	THE COURT: And so if it's not case specific it's not considered for the truth and so what is the probative valve these articles from the courts prospective if it's not admitted for the truth.
	MR. MYERS: Because they allow the court to evaluate as the trier of fact they allow the court to evaluate the basis of her opinion, if she can establish that these articles are from well accepted journals and I would cite the court to [citation] it looks like page 704 where the supreme court specifically said, this is our supreme court, this is in 1984, the court that is the trial court properly permitted plaintiff to read certain passages from documents and to question witnesses concerning them. This is a case in which we had an expert who relied upon the professional literature, it doesn't do the trier of fact any good to evaluate Dr. Mercer's testimony if we can't explain some of the literature, it would take days to do all that she's learned, but some of the literature that's particularly pertinent to this case but that is not case specific to help the court evaluate whether or not to believe her testimony, that's what we're trying to do here.
	THE COURT: So if the court grant the request to admit these exhibits when I read them or review them, is it your understanding I would not be reading them for the truth but merely to put her testimony in context.
	MR. MYERS: Well, Your Honor, that would be my backup position. My preferred position would be and I will offer them for the truth of the matter asserted and if there's an objection and the court sustains the objection I'll make an offer of proof as to each article and ask they be included in the record. The hearsay objection I will cite and I will state quite candidly that it's not one that I'm familiar with and I don't think there's much case law on it is Evidence Code Section 1341.
	THE COURT: Learning treatises?

	MR. MYERS: Well, it is learning treatises, yes, this is the learning treatise exception, it's 1341, and I'll just make, it's very short.
	THE COURT: Go ahead.
	MR. MYERS: The article is that the exception if somebody doesn't have the Evidence Code before them is that historical works, books of science or art and published charts made by persons in different between the parties are not made inadmissible by the hearsay rule when general notoriety and interest and again there's almost no case law that I can find interpreting1314. I know that the California courts are more restrictive on the admissibility learning treatises that most states are today for the truth of the matter a served but I would make the argument that the subject of childhood attachment is such widespread the court could also take judicial notice on this as an aspect to psychology that attachment is something that a general notoriety and interest.
	THE COURT: Does this matter that these are articles and not books.
	MR. MYERS: I don't think so because it says books and science but I would suggest to the court that this statute is been active in 1965 when the enacted and 1 it shouldn't make a difference whether it's a book or articles.
	THE COURT: Ms. Mojaddidi, any arguments on this?
	MS. MOJADDIDI: Your Honor, my only hesitation is that I think he's anticipating admitting several lengthy exhibits which I haven't had any time to review and so what I would ask Your Honor is to just maybe reserve on the admissibility and to the extent that he can proceed with his questioning, maybe I can just take a quick look during the break to see what exactly these things are. I haven't had that opportunity.
	THE COURT: So I will defer on admitting these. I want to take a second look at the Evidence Code section 1341. I will allow counsel to proceed with his examination using these documents but there ultimate admissibility I will defer.
	MR. MYERS: All right. And, Your Honor, we have the admissibility in two spears, we have the truth of the matter asserted, one which is probably my weakest position although I believe I need to preserve the record with offers of proof as to each article and its entirety so I would ask the court to at least permit them to be part of the court record.
	THE COURT: That is correct, they're being sought under two different rubrics. I will allow you to proceed. I haven't yet ruled as to how they will come in whether for the truth or merely as documents that she's reviewed but I will let you proceed. I will defer on my ultimate ruling.
	MR. MYERS: Thank you, Your Honor
	MR. POSNER: Is it more than review or also relied upon as opposed to just reviewed?

	THE COURT: Correct. Understood. Understood. And just to talk about where were at, in about 5 minutes I'm going to take a break from this case and turn to some other folks in the room so I'll let you go another5 or 10 minutes, Mr. Myers, and then we'll take a break.
	MR. MYERS: Yes, Your Honor, this process will take some time.