Editor:

Thank you for the publication of our paper, "Emerging Perspectives on Adolescents and Young Adults With High-Functioning Autism Spectrum Disorders, Violence, and Criminal Law," in Volume 40, Number 2 of *The Journal*. We are writing to submit a correction to a misstatement in the published manuscript:

On page 178, the sentence that reads:

> The New Jersey statute goes so far as to mandate expert evaluation of defendants suspected of carrying a diagnosis of autism. . . .

should in fact read:

> The *Florida* statute goes so far as to mandate expert evaluation of defendants suspected of carrying a diagnosis of autism. . . (emphasis added).

We apologize for this oversight and appreciate your help in alerting the readership to the correction.

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Editor:

I feel compelled to respond to the contention of Houchin and colleagues in the January issue that "there remains a paucity of scientific evidence that PAS or (PAD) should be a psychiatric diagnosis" (Ref. 1, p 128). The authors have dismissed a wealth of empirical evidence, research studies, and anecdotal documentation in support of its existence by the practices of mental health and matrimonial professionals throughout the world: for example, 30 contributors to *The International Handbook of Parental Alienation Syndrome*[2] and approximately an additional 50 contributors to *Parental Alienation, DSM-5, and ICD-11*.[3] I further contributed to the documentation in my 2012 book, *The Parental Alienation Syndrome: A Family Therapy and Collaborative Systems Approach to Amelioration*.[4]

Although child psychiatrist Richard Gardner,[5] in 1985, was the first to label a specific family interactional pattern as PAS, there has been a long history dating to the 1950s of child psychiatrists and family therapists, including but not limited to Ackerman,[6] Bowen,[7] Jackson,[8] Minuchin,[9] who noted in their practices the characteristic interactional pattern of the PAS family: namely, the co-option by one parent of a child to the deprecation and exclusion of the other parent. This pattern was confirmed by second-generation family therapists. They did not apply the label of parental alienation syndrome to this family interactional pattern.

The authors' fear that a formal diagnosis of PAS will enable and encourage mental health and matrimonial professionals to promote an adversarial legal process between the parents. To the contrary, the principal purpose of my book encourages the acceptance of the PAS into the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[10] so that intervention can be taken early and effectively, when there is the greatest likelihood of promoting collaboration between the parents and avoiding an adversarial legal proceeding.

Therapists need guidance by the DSM in making an informed diagnosis that will also rule out alienation when it is not present. Only then can mental health professionals educate matrimonial and judicial professionals to nip this dysfunctional interactional pattern in the bud when it is present and rule it out when false allegations of alienation are made.

Indeed, it is the lack of clarity that has led to the excessive "money trail" (Ref. 1, p 129). Ambiguity creates an environment for litigation. Clarity would mitigate the likelihood of the need for forensic evaluations and adversarial court proceedings.

Without a diagnosis, children and families of divorce will be precluded from receiving the necessary mental health treatment services to remedy this dysfunctional interactional pattern, and the members of the judicial community will be at a loss to order the necessary treatment services when these situations do exist.

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Editor:

The article by Houchin *et al.*[1] in the January issue deserves response from every professional community concerned with parental alienation (PA). I represent the mental health community as a psychotherapist who has treated PA-affected families for years. The article contains many distortions that should be addressed; I will limit myself here to two points.

First is their argument that "parental alienation as a psychiatric diagnosis has arisen from emotions . . . rather than from sound, scientific study" (Ref. 1, p 127). I can refute this argument simply by explaining the clinical rationale for parental alienation syndrome (PAS) as a psychiatric diagnosis.

Knowledgeable therapists know that PAS presents clinically distinct psychiatric problems that must be regarded as such to realize effective treatment for children. Child victims of PA can present with a plethora of symptoms, including developmental delays and responses along the full spectrum of dissociative disorders. What makes diagnosis and treatment of PAS so singular is the pernicious constellation of mental, emotional, cognitive, and psychosocial features that are specific to the PA experience.

The particular type and amount of suffering that any child endures are heavily influenced by dynamics unique to the phenomenon of PA, such as the child's terrible role as co-opted alienator and his paradoxical position of unrelenting powerlessness juxtaposed against rigidly enforced parentification. For this reason, accurate diagnosis and effective treatment must be based on a nuanced knowledge of the nature (including origins, dynamics, and effects) of PA and PAS.

The suggestion that emotions and opportunism motivate my colleagues and me to do our demanding and intricate work with these troubled patients impugns the meaning of our careers and demeans us.

My second point concerns the assertion of Houchin *et al.* that ". . . adopting PAS . . . as a formal diagnosis in the DSM-5 serves only to further confuse mental health practitioners and the courts" (Ref. 1, p 130). Their opinion runs contrary to all my experience in working with PAS patients, families, and professionals. Clinicians eagerly await specific PA/PAS terminology. The context of high controversy, adversarial argument, bitter allegiances, and contradictory histories obfuscates every case of PA. In this atmosphere, accuracy and clarity are as important as they can be elusive. Clinicians want to rely on terms that are correct and precise. We are at a serious disadvantage in ensuring effective outcomes for children if we cannot depend on clear communication through uniform and widely accepted terminology.

Houchin *et al.* defeat their own argument through use of confusingly inconsistent acronyms throughout the article: for example, "PAS (or PAD)," and "PAS" or "PAS(D)." They quote Johnston and Kelly as saying, "PAS terminology has led to widespread confusion and misunderstanding in judicial, legal, and psychological circles" (Ref. 2, p 250). If this is so, then standardized terminology, coding, and diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[3] will go a long way toward resolving this confusion, not contributing to it.

References

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