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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.

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