Parental Alienation, DSM-5, and ICD-11: Response to Critics

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There has been considerable interest among forensic practitioners in the proposals that parental alienation be included in the next editions of the Diagnostic and Statistical Manual of Mental Diseases (DSM) and The International Classification of Diseases (ICD). However, there has also been a great deal of misunderstanding about the proposals, and misinformation has been expressed in professional meetings, on websites, and in journal articles. In this article we address four common misunderstandings regarding parental alienation: that there is a lack of research to support it as a diagnosis; that adopting parental alienation as a diagnosis will lead to serious adverse consequences; that the advocates of parental alienation are driven by self-serving or malevolent motives; and that Richard Gardner should be criticized for self-publishing his description of parental alienation syndrome.

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For several years, there has been considerable interest in the proposals that parental alienation (PA) be included in the Diagnostic and Statistical Manual of Mental Diseases, Fifth Edition (DSM-5),[1] and the International Classification of Diseases, Eleventh Edition (ICD-11). The original proposal, which was quickly prepared by a small group of mental health professionals, was published in October 2008.[2] A much more elaborate proposal, with 70 contributing authors, was published in March 2010.[3] The second proposal, along with a good deal of additional information, was published as a book, *Parental Alienation, DSM-5, and ICD-11*, in October 2010.[4] The formal proposals, which were submitted to the DSM-5 Task Force of the American Psychiatric Association, and the book have generated a great deal of comment and discussion at meetings of mental health professionals, on blogs and websites, and in professional journals.

Three articles criticized the proposal that PA be included in DSM-5: an article by Walker and Shapiro,[5] an article by Houchin, *et al.*,[6] and a review of *Parental Alienation, DSM-5, and ICD-11* by Pepiton *et al.*[7] The current article was written to continue this dialogue by identifying and addressing several errors and misunderstandings put forth in those three publications. Although we disagree with many of their statements and most of their conclusions, we appreciate the authors' willingness to participate in a scholarly dialogue regarding the place of PA in psychiatric nosology.

We have discussed this provocative topic, whether the words parental alienation should be included somewhere in DSM-5 and ICD-11, with hundreds of mental health and legal professionals. We have heard a wide range of opinions, comments, endorsements, and denunciations. Many colleagues have made helpful suggestions regarding the definition of PA and the proposed criteria for its diagnosis. Some colleagues have expressed concern about labeling children of high-conflict divorce with a mental condition. Some said they worried that PA, if it becomes an official diagnosis, would be misused in legal settings. We have been concerned that many of the objections to our proposals raised by our colleagues are based on misunderstandings and misinformation. For example, we have been told several times that the research base for the PA diagnosis is not robust enough. At times, we have been confronted with outright disinformation (i.e., obviously false statements) intended to discredit the proposals that we submitted to the DSM-5 Task Force.

The purpose of this article is to address some of the most common misunderstandings regarding our proposals that PA be included in DSM-5 and ICD-11. To create a conversation, we will use statements

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from the Walker and Shapiro,[5] Houchin *et al.*,[6] and Pepiton *et al.*[7] articles to illustrate the misunderstandings that we believe need to be corrected. We hope that this effort will promote further discussion. The four misunderstandings we will address here are: there is not enough published research to support the inclusion of PA in DSM-5 and ICD-11; if PA becomes a diagnosis, its misuse will influence judges to remove children from protective parents and put them in the custody of abusive parents; the people who advocate that PA should be included in DSM-5 and ICD-11 are motivated by hidden agendas or ulterior motives, such as winning court cases and earning money as expert witnesses; and Richard Gardner should be criticized for self-publishing his description of parental alienation syndrome (PAS).

First, for readers who are not familiar with the concept, our definition of PA is a mental condition in which a child, usually one whose parents are engaged in a high-conflict separation or divorce, allies himself strongly with one parent (the preferred parent) and rejects a relationship with the other parent (the alienated parent) without legitimate justification. PA features abnormal, maladaptive behavior (refusal to have a relationship with a loving parent) that is driven by an abnormal mental state (the false belief that the rejected parent is evil, dangerous, or unworthy of love).

Qualitative and Quantitative Research Regarding Parental Alienation

One of the criticisms of our proposals has been the argument that there is not enough research for PA, PAS, parental alienation disorder (PAD), or parental alienation relational problem (PARP), to be considered a diagnosis in DSM or ICD. This criticism is reflected in the statement published by the American Psychological Association: "The American Psychological Association has no official position on 'parental alienation syndrome.' . . . There is no evidence within the psychological literature of a diagnosable parental alienation syndrome."[8] Critics of PA theory allege that no (or not enough) research has been published in peer-reviewed professional journals to support the inclusion of parental alienation in DSM-5 and ICD-11.

In the three articles under consideration here, Walker and Shapiro wrote, "There is no. . .body of scientific, empirical, or clinical literature to support the construct of PAD" (Ref. 5, p 279). Similarly, Houchin *et al.* said, "There remains a paucity of scientific evidence that PAS (or PAD) should be a psychiatric diagnosis" (Ref. 6, p 128). Pepiton *et al.* stated: "This book consists of mostly unsupported opinion and anecdotal reports. . . . The book completely fails to provide documentation of any empirical research supporting such a condition or diagnosis and instead is a long diatribe of a person promoting his own agenda with only anecdotal or unscientific references" (Ref. 7, p 252).

Although the concept of PA has been recognized by mental health professionals since the 1940s, it was not until 1985 that Richard Gardner[9] identified eight behaviors of a child that he proposed indicated that the child was unjustifiably alienated from one parent, usually because of the manipulations of the favored parent. The eight behaviors were: the child's campaign of denigration against the target parent; frivolous rationalizations for the child's criticism of the target parent; lack of ambivalence; the independent-thinker phenomenon; reflexive support of the alienating parent against the target parent; absence of guilt over exploitation and mistreatment of the target parent; borrowed scenarios; and spread of the child's animosity toward the target parent's extended family. Gardner argued that these eight behaviors could aid in differentiating realistic estrangement (i.e., rejecting an abusive parent) and alienation (rejecting a nonabusive parent to please the favored parent). He based his delineation of these behaviors on years of clinical observations of children during custody evaluations. He chose to refer to this phenomenon as a syndrome, as it reflected a common set of symptoms.

Since the 1980s, there has been a good deal of empirical research, a wealth of descriptive, qualitative research and a lesser amount of quantitative research regarding PA and PAS. In this article, we focus on research that pertains to the validity of the eight behaviors described by Gardner. First, considering qualitative research, many authors from many countries have described the eight symptoms identified by Gardner in their own patients. For example, in 1994 Dunne and Hedrick[10] reported on 16 cases that they believe reflected PAS as defined by Gardner. That is, they were able to identify cases in which the children behaved in a manner that was consistent with the behavioral manifestations of PAS.

In 1996, Waldron and Joanis[11] described children who had been subjected to the alienating parent's efforts, which were described as, "so ruthless, sophis-

ticated, and persistent, playing heavily on the loyalties, fears, and even trust of the child, that the child's ability to maintain an independent relationship with the target parent will slowly be crushed" (Ref. 11, p 2). These children were described as adopting the themes of the alienating parent, refusing to take into account contradictory evidence, spying on the target parent, and believing every word of the favored parent despite the parent's obvious lies and manipulation. Their clinical description of alienated children was entirely consonant with Gardner's.

In 2001, when Kelly and Johnston[12] offered a "reformulation" of Gardner's model of alienation, they defined an alienated child as "one who expresses, freely and persistently, unreasonable negative feelings and beliefs (such as anger, hatred, rejection, and/or fear) toward a parent that are significantly disproportionate to the child's actual experience with that parent" (Ref. 12, p 251). That definition is close to our own definition of PA. Kelly and Johnston provided a lengthy description of typical behaviors of alienated children, including the following words and phrases: "freely express hatred or intense dislike toward the rejected parent," "demonize and vilify that parent, often present trivial reasons to justify their hatred," "usually are not reticent about broadcasting the perceived shortcomings of the parent to others," "strongly expressed resistance to visiting the rejected parent," "allegations about the rejected parent are mostly replicas or slight variants of the aligned parents' allegations and stories," "scripted lines are repeated endlessly," "do not have compelling supporting information," "appear not to be guilty or ambivalent as the children denigrate, often viciously, the rejected parent," "hostile and rude toward the rejected parent, grandparents, and other relatives," and "vigorously reject any suggestion that their obsessive hatred of the rejected parent has any relationship to the views or behaviors of the aligned parent" (Ref. 12, pp 262–3). Needless to say, most if not all of Gardner's eight behavioral manifestations are reflected in this description. Kelly and Johnston, who have written extensively about PA and PAS, clearly concur with the clinical picture of how an alienated child behaves.

In developing the bibliography for *Parental Alienation, DSM-5, and ICD-11*, the authors and their colleagues collected approximately 500 references regarding PA from the professional literature of about 30 countries. We wanted to include those international sources because we hoped to influence the writers of ICD-11, which is produced by the World Health Organization. We have found many scholarly books, chapters, and articles that provide case reports of PA. For example, Lena Hellblom Sjögren's book, *The Child's Right to Family Life*, describes in detail 25 case studies of PA in Sweden.[13] Also, Professor Guglielmo Gulotta and his colleagues in Italy explained their research into the pathogenesis of PAS in *The Parental Alienation Syndrome (PAS): Brainwashing and Programing of Children to the Detriment of the Other Parent.*[14] We have summarized here only a few examples of qualitative research out of hundreds of articles and book chapters from diverse cultures, religions, and political systems on six continents. We believe that the diversity itself helps to validate the reality of the symptoms originally described by Gardner. Although this type of research is indeed descriptive and qualitative, it is incorrect to characterize it as "only anecdotal or unscientific references" (Ref. 7, p 252).

In recent years, quantitative empirical research regarding PA and PAS has also been conducted. For example, Rueda[15] conducted the first inter-rater and test-retest reliability study to address the eight symptoms of PAS. Mental health professionals were asked to examine five clinical vignettes and to answer questions regarding the behavioral manifestations of PAS as described by Gardner, including 10 questions regarding parent behavior and 13 questions regarding child behavior. Morrison[16] conducted a replication of the Rueda study. Although both studies had limitations (including failure to publish the actual vignettes and small sample sizes), Rueda and Morrison reported agreement and consensus among evaluators working independently, as well as a high degree of test-retest reliability. Both studies were summarized in Bernet (Ref. 4, pp 91–6).

In a 2007 study, Baker and Darnall[17] surveyed 68 parents of children who were severely alienated (as identified by the surveyed parents). Parents responded affirmatively to the statement, "Your relationship with your child is currently severely damaged because of the actions and attitudes of the other parent. Your child professes to want nothing to do with you and access is minimal at best" and then indicated the frequency with which their children exhibited 16 behaviors, 8 of which were Gardner's behavioral manifestations of PAS, while the others were not. In addition to indicating which behaviors

were consistent with their child, they also were asked to share a brief example or story (which allowed the researchers to confirm the veracity of the endorsed items). Results revealed that the eight behavioral manifestations were in fact exhibited by the severely alienated children, while the other behaviors were not.

Also, Baker *et al.*,[18] surveyed 40 children seen at an agency for children of high-conflict divorces, 19 of whom were deemed by the judge to be alienated (rejecting a parent who does not deserve to be rejected) and 21 of whom were not. The children were asked to complete a brief paper-and-pencil questionnaire of 28 items regarding their thoughts and feelings about their two parents. Questions on the survey were designed to tap some of the eight behavioral manifestations, including campaign of denigration, lack of ambivalence, absence of guilt, reflexive support for the favored parent, and rejection of the extended family. (Use of other behaviors, i.e., borrowed scenarios; weak, frivolous, and absurd reasons; and independent thinker, were not deemed amenable to self-report items.) In addition, clinicians unfamiliar with the children's responses to the items rated the children's cooperation with treatment, and a third set of individuals coded the charts for the presence of indicated abuse or neglect. Children's responses to the survey were coded by a researcher blind to the status of the children as well as all of the other data points. Each child was classified as alienated or not, on the basis of the responses to the questions. Results revealed that 18 of the 19 children sent for reunification therapy were coded as alienated based on their responses to the survey. None of these children was found to have been abused (although one was deemed neglected), and half were reported to be resistant to treatment. In comparison only 4 of the 21 children sent to the agency for reasons related to high-conflict divorce, but not to reunification therapy, were coded as alienated. Five of the 21 had indicated abuse and neglect, and none was described as resistant to treatment. These data are consistent with the notion that a subset of children from high-conflict divorces behave in a manner that is consistent with Gardner's description of alienated children, in the absence of abuse and neglect.

A final source of validity for the eight behavioral manifestations of PAS comes from the clinical literature on the typical behavior and attitudes of children who have documented experiences of abuse. This aspect is relevant in light of a criticism of PAS theory that argues that children who reject a parent and refuse visitation with that parent are doing so for valid reasons, such as child abuse or neglect. However, the clinical literature on abused children is quite consistent on the point that they do not typically reject the parent who perpetrated the abuse against them. In fact, the opposite is more likely the case. Abused children, rather than blaming the abuser, will preserve the idea of the good parent.[19] They would rather adopt the belief that they caused and deserved the abuse, which allows them to maintain the relationship with the abusive parent. In sum, not only is there ample and mounting evidence that some children who resist visitation exhibit the eight behavioral manifestations of PAS, there is no countervailing evidence that abused children exhibit these behaviors. As noted above, the children in the study by Baker *et al.*[18] who were abused did not exhibit signs of alienation in the questionnaire, nor did they resist treatment with the abusive parent.

The research discussed herein pertains to the validity and reliability of the eight behavioral symptoms of PA. We have made no attempt to summarize the research on other aspects of that topic. Although we agree that additional quantitative research regarding PA is necessary, it is incorrect to say, "Many scholars have consistently encountered a lack of empirical studies published in peer-reviewed journals" (Ref. 6, p 129), and, "the book completely fails to provide documentation of any empirical research supporting such a condition or diagnosis" (Ref. 7, p 252). Writers who make such assertions are simply unaware of the vast international literature regarding PA or they have failed to look carefully at the references in the book, *Parental Alienation*, *DSM-5*, *and ICD-11*. Although there is a need for additional quantitative research, we do not believe that those limitations and directions for future research invalidate the simple fact that there is a vast body of clinical and empirical literature documenting the existence of PA and its negative consequences for children.

Potential Misuse of Parental Alienation Diagnosis

Critics of PA frequently say that PA/PAS/PAD/PARP should not become an official diagnosis because it could lead to serious unintended consequences. In particular, they are concerned that the inclusion of PA in DSM-5 will lead to widespread

misuse of the concept by abusive fathers whose children do not want to visit them because of past mistreatment. Critics say those fathers will blame the contact refusal on PA, and unwitting judges will transfer the children from their protective mothers to their abusive fathers. For example, the National Organization for Women Foundation has actively opposed the proposal regarding PA and DSM-5, saying, "This accusation [of parental alienation disorder] is made by abusive ex-husbands and is intended to cause the courts to disregard mothers' claims of fathers' physical or sexual abuse in an effort to gain the fathers' full or joint custody."[20]

Pepiton *et al.* raised the same concern stating, "[Bernet] does not discuss what the outcome of placing a child with an abusive parent might be. To many professionals in the field, this would seem like the worst possible outcome for a child" (Ref. 7, p 250). Likewise, Walker and Shapiro wrote:

> Anecdotal and clinical evidence supports the view that since PAS has been introduced in the courts, it is frequently mothers who are accused of being the alienators against fathers in divorce cases where women also claim to be domestic violence victims. Often these women are attempting to continue to protect the children from an abusive father, and their protective behavior may appear to be alienation [Ref. 5, p 276].

We are fully aware that, in high-conflict custody battles, both true and false allegations against the other parent are liberally introduced by one or both parties. Although it is common for one of the parents to allege PA, there is no evidence that this will occur routinely. For the most part, judges are conscientious, hard working, and concerned about the welfare of children and will not be easily misled into placing a child with an abusive parent when there is valid evidence of that parent's maltreatment of the child. While this unfortunate outcome may have occurred a few times, there is only one example published in a peer-reviewed journal describing a case in which a judge wrongly placed a child with a parent after that parent introduced the PA argument. The case was *Wilkins v. Ferguson*,[21] which was discussed by Meier.[22]

One way to prevent the misuse of PA by abusive parents (men or women) is to have consensus regarding the diagnosis. An abusive parent claiming that a child refusing visitation was alienated would find it difficult to show that the child manifested the behavioral symptoms required for the diagnosis of PA. However, it is relatively easy for abusive parents to claim that their children have been manipulated if there is no uniform definition of PA, and mental health professionals remain untrained regarding the identification and differential diagnosis of PA.

Motivations of Parental Alienation Advocates

In highly emotional disagreements, there may be a tendency to attribute ulterior motives to one's opponent. That has certainly happened with regard to the idea that PA should be included in DSM and ICD. One writer went so far as to say that advocates of our proposals regarding PA and DSM-5 include " 'father's rights' groups who don't like to be interfered with when they are sexually abusing their children. The group has petitioned the DSM task force to include PAS in the publication" (Ref. 23, p 6). Walker and Shapiro attributed an ulterior motive to the mental health professionals who developed the proposal that PA be included in DSM-5. They said, "The proposed category of PAD is specifically designed for use during high-conflict divorce cases" (Ref. 5, p 278).

Along the same lines, Houchin *et al.* opined, "As with any heated controversy, one must examine the possible financial motivations that may influence the positions of those engaged in debate. Unfortunately, to get a good sense of PAS's support, one has only to follow the money trail" (Ref. 6, p 129). They also said, "One has to wonder if some of the interest on the part of mental health practitioners supporting the inclusion of PAS or PAD in DSM-5 has more to do with economic self-interest than with any belief that it would lead to improved clinical practice" (Ref. 6, p 130).

The statements of Houchin *et al.*[6] regarding the possible financial motivations of ourselves and the other supporters of our proposals are unfounded. Some of the advocates of our proposals regarding PA and DSM-5 have organized themselves as the Parental Alienation Study Group (PASG). The members of PASG are mental health professionals, legal professionals, and others with a deep interest in this topic. The mental health experts and the legal practitioners who belong to PASG are very busy with their work and do not need PA to become an official psychiatric diagnosis to maintain their practices. Expert witnesses will continue to evaluate families and testify regarding the phenomenon of alienation, even

if the words parental alienation are not included in DSM or ICD.

There are heated controversies over many DSM-5 proposals (e.g., regarding autism spectrum disorders), the diagnosis of bipolar disorder in children, the callous and emotional specifier for conduct disorder, and the classification of personality disorders. However, we do not think it is necessary to follow the money trail to understand the motivations of the clinicians and researchers engaged in those debates.

In our opinion, the authors of the proposals that PA be included in DSM-5 and ICD-11 are motivated by two goals: first, we are advocating for the truth (i.e., an honest, scientific fact). On the basis of our own experiences and readily available professional literature, we have concluded that the mental condition of PA, as we define it, really exists. Most mental health and legal professionals who work with divorced families agree that PA exists, although they may not agree that PA should be a diagnosis in DSM-5. In an informal survey of members of the Association of Family and Conciliation Courts, 98 percent of the 300 respondents endorsed the statement, "Some children are manipulated by one parent to irrationally and unjustifiably reject the other parent."[24] Second, we feel strongly that, whenever possible, children should grow up with healthy relationships with both parents. PA needs to be recognized and addressed in the early stages when it is treatable, before it progresses to the most severe form of PA, total parentectomy. When PA becomes officially recognized as a serious mental condition, mental health trainees will learn about it in school, mental health practitioners will recognize it sooner rather than later, and researchers will develop and evaluate evidence-based practice to treat it.

Criticisms of Richard Gardner

It is common for critics of PAS and of our proposals regarding DSM-5 also to criticize Richard Gardner,[9] who coined the term parental alienation syndrome. For example, Hoult said, "Gardner largely insulated his work from peer review by self-publishing, using his personal publishing company, and republishing his self-published materials" (Ref. 25, p 16). In a similar vein, Walker and Shapiro said, "Gardner had no empirical data to support this theory [of PAS], and in fact, self-published his ideas" (Ref. 5, p 275). Houchin *et al.* said, "Gardner started the PAS movement, citing his own, self-published works as evidence that PAS is a mental illness" (Ref. 6, p 130).

Although it is correct that Gardner was a prolific writer who self-published some of his books, he published scientific papers regarding child custody and PA in peer-reviewed journals such as the *Family and Conciliation Courts Review*,[26] the *Journal of the American Academy of Matrimonial Lawyers*,[27] the *Journal of Divorce and Remarriage*,[28] the *American Journal of Family Therapy*,[29,30] the *American Journal of Forensic Psychology*,[31] and this journal,[32] among others.

Finally, Pepiton *et al.*[7] criticized our use of certain terms and phrases when describing Gardner's work, including the Grounded Theory Method and triangulation. We agree that Gardner did not employ all the rigorous safeguards required in the fully developed use of the Grounded Theory Method. We appreciate Pepiton and her colleagues' clarification of Grounded Theory Method and triangulation when used in a research context. However, it is incorrect to say that "Gardner had no empirical evidence" (Ref. 5, p 275). Gardner was a clinician who made careful observations of the patients he evaluated, much as Leo Kanner[33] did when he introduced the term "autistic disturbances of affective contact" and Hans Asperger[34] did when he described *Autistischen Psychopathen* (autistic psychopaths) in childhood. It is also important to note that Gardner died almost 10 years ago. What Gardner did or did not do is not relevant to whether PA should be included in the next editions of DSM and ICD in light of the extensive clinical and research attention it has received.

Conclusions

We could continue this conversation for several more pages, but those are the most significant misunderstandings and examples of misinformation that we think must be clarified and corrected. There are powerful reasons for PA, as defined in our proposals, to be included in DSM-5 and ICD-11. There is almost no dispute among mental health professionals who work with children of divorced parents that PA occurs in many children whose parents engage in persistent, intense conflict. These children and families should be identified early in the process, when their condition is more easily treated. For that to happen, mental health trainees and practitioners must be educated about the prevalence and symptoms of PA. It is important to broaden and deepen both the qualitative and quantitative research regard-

ing PA. The inclusion of PA in the next editions of DSM and ICD will facilitate research regarding this mental condition, will strengthen the awareness and understanding of clinicians for PA, and will increase the likelihood that children of divorce will have healthy relationships with both of their parents.

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