

Parental Alienation Syndrome: A Review of Critical Issues

by
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I. Introduction

Attorneys who litigate child custody cases are accustomed to hearing clients charge that their children are being turned against them by the other parent.¹ Allegations of this sort elicit a complex array of questions, consequences, and emotions. The most important consideration in these circumstances is that when an allegation of this kind is raised it does not bode well for the children involved.²

If the allegation of manipulation against the other parent is false, then one parent seriously misinterprets certain familial behavior or is lying about the actions of the other parent. Neither exemplifies the kind of role modeling to which children should be exposed.

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¹ See Stanley S. Clawar & Brynne V. Rivlin, *Children Held Hostage: Dealing with Programmed and Brainwashed Children* (1991); Kenneth Byrne, *Brainwashing in Custody Cases: The Parental Alienation Syndrome*, 4 AUSTL. FAM. L. 1 (1989); Michael R. Walsh & J. Michael Bone, *Parental Alienation Syndrome: An Age-Old Custody Problem*, 71 FLA. B.J. 93 (1997).

² At a minimum, this indicates the existence of significant conflict between the parents, and there is ample scientific evidence that interparental conflict can be harmful to the children involved. Paul Amato & Alan Booth, *The Legacy of Parents' Marital Discord: Consequences for Children's Marital Quality*, 81 J. PERS. SOC. PSYCHOL. 627 (2001); Paul Amato & Bruce Keith, *Parental Divorce and the Well-Being of Children: A Meta-Analysis*, 110 PSYCHOL. BULL. 26 (1991); Katherine M. Kitzmann & Robert E. Emery, *Child and Family Coping One Year After Mediated and Litigated Child Custody Disputes*, 8 J. FAM. PSYCHOL. 150 (1994); Anita K. Lampel, *Children's Alignment With Parents in Highly Conflicted Custody Cases*, 34 FAM. & CONCILIATION. CTS. REV. 229 (1996).

When the allegation of alienation is true and *deserved*,³ then one parent has behaved in a way that hurts the children; if proper warnings are not given, these minors would be inadequately protected. An example of a parent deserving alienation would be one with a repeated history of physically abusing his or her children in an unpredictable manner that has failed to respond appropriately to numerous professional attempts to control the destructive behaviors.

If the allegation that one parent is turning the children against the other parent is true but the alienation is unjustified, this too is harmful to the children. It is this special category of abuse⁴ that will be the focus of the present paper.

In light of the seriousness of unjustly turning a child against his or her own parent, it is appropriate for the judiciary to look to mental health professions for guidance. Unfortunately, for many years the problem of unjust alienation received inadequate attention in the psychological literature.⁵ This began to change in 1985 when the American Academy of Psychoanalysis published an article by Dr. Richard Gardner, a psychiatrist from Columbia University, who identified an abnormality termed *Parental Alienation Syndrome*, defined as follows:

The parental alienation syndrome (PAS) is a disorder that arises primarily in the context of child-custody disputes. Its primary manifestation is the child's campaign of denigration against the parent, a campaign that has no justification. The disorder results from the combination of indoctrinations by the alienating parent and the child's own contributions to the vilification of the alienated parent.⁶

Over the years, this description has given rise to a literature consisting of over 100 professional articles and books on PAS

³ Naturally, there may be debate about what qualifies as *deserved*, but for the purpose of this manuscript, the author is referring to harmful behaviors that all observers would agree on categorizing as *deserved*.

⁴ See Richard A. Gardner, *Differentiating Between the Parental Alienation Syndrome and Bona Fide Abuse-Neglect*, 27 AM. J. FAM. THERAPY 97 (1999).

⁵ See Ira Daniel Turkat, *Child Visitation Interference in Divorce*, 14 CLINICAL PSYCHOL. REV. 737 (1994).

⁶ See Richard A. Gardner, *Recent Trends in Divorce and Custody Litigation*, 29 ACAD. F. 3 (1985).

that offers clinical characterizations, theoretical formulations, and considerable controversy.⁷

The present article will analyze some of the key features of this literature.⁸ To begin, the author will lay a foundation for understanding PAS by reviewing its definitional criteria, its postulated pathogenesis, and its subtypes. Next, PAS' placement in psychiatric classification, including its relationship to official diagnostic categories of psychopathology, will be delineated. The article then reviews the state of the research literature on PAS. In particular, specific indicators for evaluating the progress of any clinical field of science will be provided and then applied to the psychological literature on PAS. This evaluation will reveal strengths and weaknesses in the current PAS literature. Specific obstacles to performing scientific investigations of PAS will be identified and suggestions for improving the sophistication of the literature will be presented. Finally, recommendations for judges managing PAS cases will be offered, and several problems that confront the judiciary and trial attorneys when dealing with PAS cases will be discussed. Various deficiencies that mental health professionals bring to this controversial area will be identified as well.

II. Parental Alienation Syndrome

In a nutshell, PAS occurs when one parent campaigns successfully to manipulate his or her children to despise the other parent despite the absence of legitimate reasons for the children to harbor such animosity. The effort to poison the relationship⁹ between the offspring and the targeted parent may be extensive and at times, relentless. The hostility may include "hints" of sex-

⁷ See Richard A. Gardner, *Parental Alienation Syndrome: Sixteen Years Later*, 45 *ACAD. F.* 10 (2001).

⁸ A comprehensive review of the literature on Parental Alienation Syndrome is beyond the scope of the present manuscript. See, e.g., Deirdre Conway Rand, *The Spectrum of Parental Alienation Syndrome (Part I)*, 15 *AM. J. FORENSIC PSYCHOL.* 23 (1997); Deirdre Conway Rand, *The Spectrum of Parental Alienation Syndrome (Part II)*, 15 *AM. J. FORENSIC PSYCHOL.* 39 (1997).

⁹ See Ira Daniel Turkat, *Relationship Poisoning in Custody and Access Disputes*, 13 *AM. J. FAM. L.* 101 (1999).

ual impropriety¹⁰ and in some cases, false allegations¹¹ of physical and/or sexual abuse.¹² Bad faith relocation attempts may surface as well.¹³

According to Gardner,¹⁴ the disorder appears most often in the context of child custody litigation but it is certainly not restricted to this population.¹⁵ Gardner has articulated eight specific criteria for the diagnosis of PAS.¹⁶

A. *Campaign of Denigration*

The parent targeted for alienation from his or her children is the recipient of ongoing animosity from both the parent instituting the alienation and their mutual offspring. The message of denigration may come in the form of direct and indirect criticisms, sarcasm, distorted communications, and/or other modes of interpersonal attack.¹⁷

B. *Inadequate Rationale for the Denigration*

When queried, the manipulated children offer weak, frivolous, or even absurd rationalizations for their hatred of the targeted parent.¹⁸ This may be associated with visitation refusal, whereby the minors claim experiencing negative emotional reactions to the alienated parent that are of questionable validity.¹⁹

¹⁰ See Glenn F. Cartwright, *Expanding the Parameters of Parental Alienation Syndrome*, 21 AM. J. FAM. THERAPY 205 (1993).

¹¹ See Kenneth H. Waldron & David E. Joanis, *Understanding and Collaboratively Treating Parental Alienation Syndrome*, 10 AM. J. FAM. L. 121 (1996).

¹² While allegations of sexual abuse and/or physical abuse arise in certain PAS cases, a review is beyond the scope of the present manuscript.

¹³ See Ira Daniel Turkat, *Relocation as a Strategy to Interfere with the Child-Parent Relationship*, 11 AM. J. FAM. L. 39 (1996).

¹⁴ See Gardner, *supra* note 4.

¹⁵ See Rand, *supra* note 8.

¹⁶ These criteria have not changed from their original description in 1985 (See Gardner, *supra* note 6) through current articulations of the disorder by its originator (See Gardner, *supra* note 7).

¹⁷ See Ira Daniel Turkat, *Management of Visitation Interference*, 36 JUDGES J. 17 (1997).

¹⁸ See Richard A. Gardner, *The Parental Alienation Syndrome: A Guide for Mental Health and Legal Professionals* (1992).

¹⁹ See Leona M. Kopetski, *Identifying Cases of Parental Alienation Syndrome—Part 1*, 27 COLO. LAW. 61 (1998).

C. *Absence of Ambivalent Feelings*

In normal interpersonal relationships it is appropriate to experience both positive and negative reactions to others.²⁰ This is particularly apparent in close relationships. For example, parents who love their teen-aged daughter may still harbor anger at her selective temper outbursts. They may adore their little boy, but cringe at the way he chooses to dress himself. In PAS, the evaluation of the targeted parent lacks appropriate balance. The alienated parent is seen as “all bad.”²¹

D. *“Independent” Thinking*

A child that is alienated unjustly against a parent is supported by the alienating parent to claim that the antagonism is a reflection of the minor’s independent judgment and not due to the campaign of the alienator.²² However, this “independent thinker”²³ may use the exact same verbiage of attack utilized by the alienating parent.²⁴

E. *Reflexive Support of the Alienating Parent*

The child manipulated inexcusably to despise the other parent aligns unconditionally with the parent instituting the alienation campaign.²⁵ Gardner compares this alignment to the “identification-with-the-aggressor-phenomenon,” a maneuver based on the principle: “If you can’t fight ‘em, join ‘em.”²⁶

F. *Absence of Guilt*

Children exploited to unfairly denigrate the targeted parent fail to display appropriate feelings of guilt about their antagonistic behavior.²⁷ The alienated parent’s feelings are generally ig-

²⁰ Drew Westen, *The Scientific Legacy of Sigmund Freud: Toward a Psychodynamically Informed Psychological Science*, 124 PSYCHOL. BULL. 333 (1998).

²¹ Cartwright, *supra* note 10.

²² See Gardner, *supra* note 18.

²³ *Id.*

²⁴ See Cartwright, *supra* note 10.

²⁵ See *id.*

²⁶ Richard A. Gardner, *The Empowerment of Children in the Development of Parental Alienation Syndrome*, 20 AM. J. FORENSIC PSYCHOL. 5 (2002).

²⁷ See GARDNER, *supra* note 18.

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nored. The affection, gifts, and/or child support provided by the targeted parent are often disregarded as well.²⁸

G. *Scenarios Are Borrowed from the Alienator*

The child utilizes the alienating parent's stories and explanations to articulate what is wrong with the targeted parent and as a rationale for despising the alienated parent.²⁹ These "borrowed scenarios" may include topics and words that are way beyond the conceptual level of functioning and/or knowledge base appropriate to a child of that age (e.g., a five year old complaining that the alienated parent is "in arrears"). As one expert has observed, "these children express themselves like perfect little photocopies of the alienating parent."³⁰

H. *Animosity Is Spread to Others Associated with the Targeted Parent*

The campaign to alienate the victimized parent may extend to his or her friends, relatives, and others.³¹ Like the targeted parent, these individuals may also be viewed with unwarranted hostility and treated with contempt.³²

As can be seen in the criteria listed above, PAS is a disorder involving the active participation of the parent and the child.³³ Gardner has emphasized that while the disorder stems from the manipulative actions of one parent against another, the contributions of the child in adopting and carrying out the alienating parent's campaign are critical to the pathogenesis of PAS.³⁴

²⁸ See Richard A. Gardner, *Judges Interviewing Children in Custody/Visitation Litigation*, 7 N.J. FAM. L. 26 (1985).

²⁹ See Cartwright, *supra* note 10.

³⁰ Cartwright, *supra* note 10, at 205.

³¹ See GARDNER, *supra* note 18.

³² See *id.*

³³ See *id.*

³⁴ Richard A. Gardner, *The Detrimental Effects on Women of the Gender Egalitarianism of Child-Custody Dispute Resolution Guidelines*, 38 ACAD. F. 10 (1994).

III. Development of Parental Alienation Syndrome

Given that PAS develops primarily during a custody battle,³⁵ it is important to understand how this disorder unfolds.³⁶ Gardner addresses the pathogenesis of PAS — a process in which one parent utilizes direct and indirect methods to produce a child preoccupied with unjustified criticism and hatred of the other parent.³⁷ He outlines four primary factors that lead to the unfolding of Parental Alienation Syndrome: brainwashing, subtle and unconscious parental programming, factors arising within the child, and situational factors.

A. Brainwashing

Gardner considers brainwashing to be “conscious acts of programming the child against the other parent.”³⁸ For example, a parent may be accused unfairly of being an “adulterer” or an “abandoner.” Or, a parent may be accused unjustifiably of providing inadequate financial support, which may be exaggerated to mislead the children to believe that terrible things are likely to happen to them. As another example, when one parent leaves the other parent, the remaining parent may make erroneous statements to the children such as, “we have been abandoned.”³⁹ The aim of such statements is to convey to the children that the rejection directed at the remaining parent applies also to the children. In addition, minor negative characteristics of the targeted parent may be significantly exaggerated. For example, a parent who has an occasional evening martini may be described as an alcoholic. Sarcastic remarks to the children about the targeted parent’s behavior are also common, such as, “what a wonderful generous gesture to actually spend a few dollars and take you to the movies for a change!”

³⁵ See Gardner, *supra* note 4.

³⁶ The ultimate goal of clinical psychology and psychiatry is to prevent psychological disorders from occurring in the first place. Understanding the etiology of an abnormality is necessary if one wishes to be able to prevent its occurrence.

³⁷ Richard A. Gardner, *Family Evaluation In Child Custody Mediations, Arbitration And Litigation* (1989).

³⁸ *Id.* at 233.

³⁹ *Id.*

B. *Subtle and Unconscious Parental Programming*

More subtle efforts to program the child against the targeted parent may include statements about him or her such as, “there are things I could say about your father (*mother*) that would make your hair stand on end, but [I am] not the kind of person who criticizes a parent to his (*her*) children.”⁴⁰ Clearly, comments of this kind have the potential to generate significant negative emotion in the child.

Visitation with the targeted parent is often sabotaged with subtle PAS programming. For example, a child in a PAS environment becomes attuned to the alienating parent’s desire for the child to despise the other parent.⁴¹ To secure acceptance, the child may make statements that suggest an uncertainty about visiting with the targeted parent or a lack of desire to do so; the alienator may then act in a “neutral” manner by instructing the child to believe that it is the child’s decision whether or not to visit with the other parent. This “neutrality maneuver”⁴² serves to further alienate the targeted parent by “passively” discouraging the child from participating in visitation. Under these circumstances, the child is likely to learn quickly to avoid open expressions of interest in visiting the “hated” parent.

Another common manipulation is to make the child feel guilty about visiting with the other parent. At times, the child might face proclamations like, “how can you leave your poor old mother (*father*)!”⁴³

C. *Factors Arising Within the Child*

According to Gardner, certain factors arise within the child that may contribute to the development of PAS.⁴⁴ For example, Gardner points out that the child’s psychological bond with the custodial parent before the divorce is often stronger than that with the non-custodial parent.⁴⁵ When the parents separate, the child may fear potential abandonment by the custodial parent,

⁴⁰ *Id.*

⁴¹ *See* GARDNER, *supra* note 18.

⁴² *See* GARDNER, *supra* note 37.

⁴³ *Id.* at 233.

⁴⁴ *See id.*

⁴⁵ *See id.*

and thus be more susceptible to aligning with the custodial parent in the effort of alienation.

Gardner also articulates a variety of psychodynamic hypotheses about what may be occurring unconsciously in the child that contribute to the genesis of PAS;⁴⁶ a review is beyond the scope of the present article.

D. *Situational Factors*

In addition to brainwashing, subtle and unconscious programming, and internal child psychodynamics, Gardner points out a variety of situational factors that may also facilitate the development of PAS.⁴⁷ For example, a child who observes a sibling being punished for openly displaying affection towards the vilified parent will learn quickly not to display such affection either. Similarly, a child who observes the alienating parent verbally abuse the targeted parent may self-protectively declare emotional preference for the alienating parent. When these psychological factors are considered as ongoing, interacting variables in the daily lives of a child and an alienating parent, it becomes easier to grasp how a PAS may develop.⁴⁸

IV. Types of Parental Alienation Syndrome

With years of experience dealing with cases of PAS since its original specification,⁴⁹ Gardner has come to conclude that the disorder has different subtypes.⁵⁰ These include the *mild, moderate, and severe* forms of PAS. Each requires consideration according to the eight specific criteria for diagnosing PAS,⁵¹ and are presented in Table 1.

⁴⁶ See *id.*

⁴⁷ See *id.*

⁴⁸ See Cartwright, *supra* note 10.

⁴⁹ See Gardner, *supra* note 6.

⁵⁰ Richard A. Gardner, *Legal and Psychotherapeutic Approaches to the Three Types of Parental Alienation Syndrome Families: When Psychiatry and the Law Join Forces*, 28 CT. REV. 14 (1991); Richard A. Gardner, *Family Therapy of the Moderate Type of Parental Alienation Syndrome*, 27 AM. J. FAM. THERAPY 195 (1999).

⁵¹ See *id.*

TABLE 1
Gardner’s Differential Diagnosis of the Three
Types of Parental Alienation Syndrome

| Primary Symptomatic Manifestation | Mild | Moderate | Severe |
|---|--|---|---|
| Campaign of denigration | Minimal | Moderate | Formidable |
| Weak frivolous, or absurd rationalizations for the deprecation | Minimal | Moderate | Multiple absurd rationalizations |
| Lack of ambivalence | Normal ambivalence | No ambivalence | No ambivalence |
| Independent-thinker phenomenon | Usually absent | Present | Present |
| Reflexive support of the alienating parent in the parental conflict | Minimal | Present | Present |
| Absence of guilt | Normal guilt | Minimal to no guilt | No guilt |
| Borrowed scenarios | Minimal | Present | Present |
| Spread of the animosity to the extended family of the hated parent | Minimal | Present | Formidable, often fanatic |
| Transitional difficulties at the time of visitation | Usually absent | Moderate | Formidable, or visit not possible |
| Behavior during visitation | Good | Intermittently antagonistic and provocative | No visit, or destructive and continually provocative behavior |
| Bonding with the alienator | Strong, healthy | Strong, mildly to moderately pathological | Severely pathological, often paranoid bonding |
| Bonding with the alienated parent | Strong, healthy, or minimally pathological | Strong, healthy, or minimally pathological | Strong, healthy, or minimally pathological |

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As can be seen in Table 1, Gardner has provided a comparison between the three versions of PAS on the eight criteria listed above and on a handful of other behavioral indicators (e.g., transitional difficulties at the time of visitation). Further, Gardner has advocated different therapeutic approaches based on the type of PAS encountered.⁵²

One of the major benefits of specifying three versions of PAS is that the dimensionality of abnormality is recognized. In other words, the severity of a particular case of PAS can be viewed on a continuum and the implication is that such a differentiation offers the potential for a more sophisticated understanding of the presenting aberrant behavior. In Table 1, Gardner illustrates this by pointing out differences in the nature of the psychopathology seen in the different PAS subtypes (e.g., the campaign of denigration is minimal in the mild type yet formidable in the severe type) and consequently, differential recommendations for management are advocated (e.g., Gardner suggests that only in severe PAS cases should a change in custody be considered).⁵³

Unfortunately, Gardner's specification of the three PAS types also creates certain problems. Researchers have noted the absence of a clear specification of how many of the eight PAS symptoms are required to make a PAS diagnosis.⁵⁴ It is also unclear as to which of the eight criteria must be present to diagnose PAS.⁵⁵ If one examines the criteria listed in Table 1, it appears that the mild case of PAS does not require the presence of a considerable number of the eight symptoms listed for diagnosis, and other symptoms only need to be minimally present. With such flexibility in the diagnostic process, the room for professional disagreement increases.⁵⁶

⁵² See Gardner, *supra* note 50 (discussing the therapeutic approaches recommended by Gardner for the three types of PAS).

⁵³ *Id.*

⁵⁴ See K. Daniel O'Leary & Kirstin C. Moerk, *Divorce, Children and the Courts: Evaluating the Use of the Parent Alienation Syndrome in Custody Disputes*, 7 EXPERT EVIDENCE 127 (1999).

⁵⁵ See Richard A. Warshak, *Current Controversies Regarding Parental Alienation Syndrome*, 19 AM. J. FORENSIC PSYCHOL. 29 (2001).

⁵⁶ See J. Michael Bone & Michael R. Walsh, *Parental Alienation Syndrome: How to Detect It and What to Do About It*, 73 FLA. B.J. 44 (1999).

An additional consideration is that there appears to be diagnostic overlap across the three subtypes. Table 1 indicates that the criterion involving reflexive support of the alienating parent is “minimal” in the mild type and “present” in the moderate and severe types.⁵⁷ Since “minimal” indicates that the behavior is present, Gardner’s description here does not optimally segregate the three subtypes. The literature establishes that diagnostic overlap can pose significant problems⁵⁸ when trying to differentiate psychiatric entities, and when investigating relationships between pertinent variables.⁵⁹ In brief, while Gardner offered the three types of PAS to facilitate diagnostic and therapeutic considerations,⁶⁰ he may have inadvertently created other problems.

V. Parental Alienation Versus Parental Alienation Syndrome

Science does not proceed without a useful classification system.⁶¹ Taxonomies permit scientists to communicate clearly about the phenomena they investigate.⁶² Differentiating one phenomenon from another is integral to advancing scientific knowledge.⁶³ In the mental health professions, phenomena are distinguished from one another using the classification system known as psychiatric diagnosis.⁶⁴ Failure to adequately differentiate between distinct psychiatric entities inhibits the growth of

⁵⁷ See Gardner, *supra* note 50.

⁵⁸ See Thomas A. Widiger & Tracie Shea, *Differentiation of Axis I and II Disorders*, 100 J. ABNORMAL PSYCHOL. 399 (1991).

⁵⁹ The problem of diagnostic overlap is not unique to PAS, and in some cases, diagnostic overlap may be appropriate. For example, a person with allergies may present with sneezing as a symptom; so may an individual suffering from a cold.

⁶⁰ See Gardner, *supra* note 50.

⁶¹ See KENNETH D. BAILEY, *TYPOLOGIES AND TAXONOMIES: AN INTRODUCTION TO CLASSIFICATION TECHNIQUES* (1994).

⁶² See *id.*

⁶³ See *id.*

⁶⁴ See Ira Daniel Turkat & Stephen A. Maisto, *Functions of and Differences Between Psychiatric Diagnosis and Case Formulation*, 6 BEHAV. THERAPIST 184 (1983).

knowledge of mental disorders at the scientific level⁶⁵ and competent service provision at the clinical level.⁶⁶

A. PAS as a Subset of Parental Alienation

Gardner considers the classification of PAS to be a subset of the broader rubric of Parental Alienation (PA).⁶⁷ According to Gardner, PA refers to a child who has been alienated from a parent, whether it is justified or not.⁶⁸ Examples include alienation due to parental abandonment, aversive interpersonal qualities of a parent (e.g., alcoholism), parental verbal abuse, and PAS. Gardner believes that a wide variety of symptoms may be seen in PA, whereas in PAS one should see behaviors indicative of the eight criteria previously described. Given Gardner's conceptualization that PAS is but one example of PA, and that other examples of PA (e.g., alienating a child from a sexually abusive parent) may be incompatible with the definition of PAS (which requires the alienation to be unjustified), it seems appropriate to follow Gardner's recommendation⁶⁹ that professionals not use the terms PA and PAS interchangeably.

B. Classificatory Issues Involving the Mild Version of PAS

The nosologic differentiation between alienation entities becomes a bit more cumbersome when one considers Gardner's description of the three PAS subtypes.⁷⁰ If in the mild version, a PAS diagnosis can be made with a considerable number of PAS criteria not being met, does it become problematic to call it a

⁶⁵ See W. John Livesley, Marsha L. Schroeder, Douglas N. Jackson & Kerry L. Jang, *Categorical Distinctions in the Study of Personality Disorder Implications for Classification*, 103 J. ABNORMAL PSYCHOL. 6 (1994).

⁶⁶ See, e.g., Carole Jenny, Kent P. Hymel, Alene Ritzen, Steven E. Reinert, & Thomas C. Hay, *Analysis of Missed Cases of Abusive Head Trauma*, 281 JAMA 621 (1999); Gerhard Jordan & Dan J. Stein, *Mental Disorders Due to a General Medical Condition*, 41 PSYCHOSOMATICS 370 (2000).

⁶⁷ Richard A. Gardner, *Parental Alienation Syndrome vs. Parental Alienation: Which Diagnosis Should Evaluators Use in Child-Custody Disputes?* 30 AM. J. FAM. THERAPY 93 (2002).

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Gardner, *supra* note 50.

case of PAS?⁷¹ If so, what should it be called? Furthermore, Gardner reports that mild cases of PAS usually do not require psychiatric intervention.⁷² If true, is a “mild” case of PAS actually representing a disorder requiring a psychiatric diagnosis?

Other psychopathological conditions may shed some light on the subject. For example, the scheme of personality disorders — one of the most common psychiatric diagnoses,⁷³ recognizes normal personality types and abnormal personality types.⁷⁴ One can, for example, distinguish between a “normal” paranoid personality and a paranoid personality disorder.⁷⁵ A normal individual may demonstrate paranoid personality traits like suspiciousness and distrust; however, it is only when these traits are enduring and cause significant problems on an ongoing basis, are they likely to be representative of a personality disorder.⁷⁶ Does such a distinction seem useful for understanding the dimensionality of PAS? Like the personality disorders, does PAS lie on a continuum of normal to abnormal? Does a mild case of PAS seem directly analogous to the non-disorder paranoid personality?

Using the paranoid personality versus paranoid personality disorder distinction as an example, if one chooses to call a mild case of PAS “PA” instead of calling it “PAS,” that would prove problematic since PAS is considered to be a subset of PA.⁷⁷ Given that PA includes both justified and unjustified alienation, calling a mild PAS case “PA” would not communicate if the

⁷¹ Not all psychiatric diagnostic categories require that every symptom be present to make a diagnosis; Gardner should not be held to a higher standard. However, when introducing a new disorder, there is less room for diagnostic uncertainty if the number of criteria that must be met is specified clearly.

⁷² Richard A. Gardner, *Recommendations for Dealing with Parents Who Induce a Parental Alienation Syndrome in Their Children*, 28 J. DIVORCE & REMARRIAGE 1 (1998).

⁷³ Michael R. Leibowitz, Michael H. Stone & Ira Daniel Turkat, *Treatment of Personality Disorders*, 5 AM. PSYCHIATRIC ASS’N ANNUAL REV. 356 (1986).

⁷⁴ See DIFFERENTIATING NORMAL AND ABNORMAL PERSONALITY (Stephen Strack & Maurice Lorr eds., 1994).

⁷⁵ See Ira Daniel Turkat & David Banks, *Paranoid Personality and Its Disorder*, 9 J. PSYCHOPATHOLOGY BEHAV. 295 (1987).

⁷⁶ See IRA DANIEL TURKAT, *THE PERSONALITY DISORDERS: A PSYCHOLOGICAL APPROACH TO CLINICAL MANAGEMENT* (1990).

⁷⁷ See Gardner, *supra* note 67.

alienation was deserved or unjustified. This is a critical point because PAS, by definition, means that the alienation is unjustified.⁷⁸

Carrying the paranoid personality versus paranoid personality disorder example a step further, a more serious problem with calling a mild case of PAS “PA” is that turning a child *unjustifiably* against a parent is *not* normal.⁷⁹ Even in the mild version of PAS, the child is taught unjustifiably to disrespect and act out against the targeted parent;⁸⁰ behavior of this kind is certainly abnormal.

As long as unjustified alienation is the hallmark of PAS, a normal version is unlikely to emerge because unjustified alienation is not normal. Relatedly, even the mild version of PAS represents abusive behavior.

C. PA and PAS Relationship Configurations

Since the term PA can be misused (and has been⁸¹) to imply a “normal” version of PAS (like the paranoid personality is to the paranoid personality disorder) or a “less worrisome” version, misapplication may be reduced if PA and PAS are viewed as distinct entities and not as a subset of the other. This, of course, would require a shift in Gardner’s current view that PAS is a subset of PA; however, it might facilitate his goal of not having these terms used interchangeably. Perhaps a larger subset of “problematic interparental behaviors” could encompass categories such as PA, PAS, and other related phenomena such as Divorce Related Malicious Parent Syndrome,⁸² domestic violence,⁸³ and Shared Parenting Dysfunction.⁸⁴ O’Leary and Moerk suggest that PAS could be viewed as a subset of emotionally abusive behaviors;⁸⁵ PA could thus be placed in a different categorization.

⁷⁸ See Gardner, *supra* note 6.

⁷⁹ See Warshak, *supra* note 55.

⁸⁰ See Gardner, *supra* note 67.

⁸¹ See *id.*

⁸² See Ira Daniel Turkat, *Divorce Related Malicious Parent Syndrome*, 14 J. FAM. VIOLENCE 95 (1999).

⁸³ See Lenore E. Walker, *Psychology and Domestic Violence Around the World*, 54 AM. PSYCHOL. 21 (1999).

⁸⁴ See Ira Daniel Turkat, *Shared Parenting Dysfunction*, 30 AM. J. FAM. THERAPY 385 (2002).

⁸⁵ O’Leary, *supra* note 54.

Another possible viewpoint on the dimensionality issue is to consider PA and PAS on a continuum, where one end of the pole represents *appropriate* alienation (e.g., a parent warns a child about the other parent that has sexually abused the child) and *inappropriate* alienation (e.g., PAS). Or, *justified* alienation and *unjustified* alienation might serve as functional anchors on such a continuum. While potentially useful conceptually, endpoints of this kind would still require some accommodation regarding: (1) PA as a broader rubric, and (2) the fact that PAS is never normal. At a minimum, a clear specification of what the threshold is to differentiate justified from unjustified alienation (or appropriate from inappropriate alienation) would be essential.

D. *Diagnostic Convenience*

A final point to be raised is a practical one: humans naturally use shortcuts when they can. Thus, when discussing a case of PAS, it is not surprising that some would use the term “Parental Alienation” in lieu of the formal “Parental Alienation Syndrome.” The misuse of diagnostic terms is not unique to PAS. For example, not too long ago, the label “borderline” was used inappropriately so frequently in the field of mental health that the term seemed to represent a “wastebasket” diagnosis.⁸⁶ Reckless use of the word “borderline” made it difficult to know if one was referring to a personality disorder, a psychosis, a mood disorder, a degree of psychopathology or some other entity, such as a “heterogenic hodgepodge.”⁸⁷ Misuse of diagnostic terms creates chaos among psychiatric researchers and clinicians.⁸⁸

Whether one is talking about Borderline Personality Disorder or PAS, a shortcut is not an adequate excuse for diagnostic sloppiness by a mental health professional. A clinician should not use the label PA when diagnosing a potential case of PAS. However, it may be unrealistic for psychologists and psychiatrists

⁸⁶ See IRA DANIEL TURKAT & ROBERT A. LEVIN, FORMULATION OF PERSONALITY DISORDERS, COMPREHENSIVE HANDBOOK OF PSYCHOPATHOLOGY 495 (Henry E. Adams & Patricia B. Sutker eds., 1984).

⁸⁷ Thomas A. Widiger, Allen Frances, Robert L. Spitzer, & Janet B.W. Williams, *The DSM-III-R Personality Disorders: An Overview*, 144 AM. J. PSYCHIATRY 786 (1988).

⁸⁸ See TURKAT & LEVIN, *supra* note 86.

to expect professionals that do not provide mental health services to be as rigid about the diagnostic distinctions.

In light of the above, Gardner's articulation of a mild, moderate, and severe form of PAS is useful, and his admonition about not interchanging the terms PA and PAS seems appropriate. Unfortunately, the lack of a threshold requirement for diagnosing PAS and other related concerns may perpetuate the kind of terminological confusion that Gardner would like others to avoid.⁸⁹

VI. Parental Alienation Syndrome and the DSM-IV

The standard for making psychiatric diagnoses is the American Psychiatric Association's Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).⁹⁰ The DSM-IV does not specifically list PAS.⁹¹ This has been used by some to argue that PAS is not a psychiatric syndrome.⁹² Those who make this argument are violating the dictums of the DSM-IV.

First, the introduction to DSM-IV states, "It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion."⁹³ Thus, the DSM-IV warns that non-mental health professionals should not be making judgments about what is and is not a mental disorder; attorneys would seem to represent one group to which this admonition likely applies. Furthermore, mental health professionals are required to exercise their own *clinical judgment* in making diagnoses, and are instructed not to rely on the DSM-IV guidelines in a *mechanical* or *cookbook* fashion.⁹⁴ As noted in

⁸⁹ See Gardner, *supra* note 67.

⁹⁰ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994). In 2000, a text revision of the DSM-IV was published, known as DSM-IV-TR; it has no significant impact on the discussion provided in the present manuscript.

⁹¹ *Id.*

⁹² See Gardner, *supra* note 67.

⁹³ AM. PSYCHIATRIC ASS'N, *supra* note 90, at xxiii.

⁹⁴ See *id.*

the DSM-IV, “the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe.”⁹⁵

Second, the DSM-IV states explicitly that there are mental disorders that have *not* been included in the diagnostic manual: “Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation.”⁹⁶ To remedy this problem, the DSM-IV provides a diagnostic entity called, “Not Otherwise Specified.”⁹⁷ Four different clinical presentations merit a Not Otherwise Specified (NOS) diagnosis.⁹⁸ One of these is: “The presentation conforms to a symptom pattern that has not been included in the DSM-IV.”⁹⁹ The NOS diagnostic label is utilized according to the type of disorder seen, such as an Anxiety Disorder NOS, a Sexual Disorder NOS or other problem that may be encountered.¹⁰⁰

In addition to NOS disorders, the DSM-IV describes the Unspecified Mental Disorder:

There are several circumstances in which it may be appropriate to assign this code: 1) for a specific mental disorder not included in the DSM-IV classification, 2) when none of the available Not Otherwise Specified categories is appropriate, or 3) when it is judged that a non-psychotic mental disorder is present but there is not enough information available to diagnose one of the categories provided in the Classification.¹⁰¹

Clearly, PAS meets the criteria for listing as a DSM-IV NOS mental disorder or Unspecified Mental Disorder (UMD). The symptom pattern seen in PAS was identified specifically over fifteen years ago,¹⁰² and since then has been independently utilized clinically by many other mental health practitioners;¹⁰³ this sug-

⁹⁵ *Id.* Thus, Gardner’s specification of a mild version of PAS is not incompatible with the concepts of diagnosis utilized by the DSM-IV.

⁹⁶ AM. PSYCHIATRIC ASS’N, *supra* note 90, at 4.

⁹⁷ *Id.*

⁹⁸ *See id.*

⁹⁹ *Id.*

¹⁰⁰ *See id.*

¹⁰¹ AM. PSYCHIATRIC ASS’N, *supra* note 90, at 687.

¹⁰² *See* Gardner, *supra* note 6.

¹⁰³ *See* Gardner, *supra* note 7.

gests that PAS appears to be a recognizable symptom complex at the clinical level. In fact, the Chairman of the DSM-III¹⁰⁴ and the DSM-III-R¹⁰⁵ (the predecessors to the DSM-IV), Dr. Robert Spitzer, endorsed Gardner's use of the term *syndrome* to describe PAS.¹⁰⁶ Without question, Spitzer is one of the preeminent researchers in the area of psychiatric diagnosis,¹⁰⁷ and has published extensively on what does and does not qualify as a psychiatric syndrome.¹⁰⁸ In essence, PAS is a DSM-IV mental disorder: it is diagnosable under rubrics of psychiatric abnormality¹⁰⁹ such as NOS or UMD.¹¹⁰

VII. Parental Alienation Syndrome and DSM-V

Gardner would like to see PAS listed specifically as a disorder in the DSM-V¹¹¹ under its own diagnostic label (i.e., not under NOS or some other diagnostic entity). The DSM-V is years away.¹¹²

To evaluate the potential of PAS being listed as a discrete diagnostic category in the DSM-V (or a later DSM edition), one needs to appreciate the process that enables a disorder to be spe-

¹⁰⁴ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980).

¹⁰⁵ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. rev. 1987).

¹⁰⁶ See Gardner, *supra* note 7.

¹⁰⁷ See Turkat, *supra* note 76.

¹⁰⁸ See Randall D. Marshall, Robert L. Spitzer, & Michael R. Leibowitz, *Review and Critique of the New DSM-IV Diagnosis of Acute Stress Disorder*, 156 AM. J. PSYCHIATRY 1677 (1999).

¹⁰⁹ The above discussion does not preclude the possibility of utilizing DSM-IV diagnoses other than NOS or UMD when clinical circumstances dictate. An example might be an Adjustment Disorder. Gardner provides a variety of other possibilities. See RICHARD A. GARDNER, *THE PARENTAL ALIENATION SYNDROME* (2d ed. 1998).

¹¹⁰ While other disorders not labeled as PAS in DSM-IV might be appropriate diagnostically for a particular PAS case, the present author's point is that the DSM-IV accommodates PAS merely by utilizing the NOS or UMD nosologic entities.

¹¹¹ Richard A. Gardner, *Denial of the Parental Alienation Syndrome Also Harms Women*, 30 AM. J. FAM. THERAPY 191 (2001).

¹¹² See Michael B. First & Harold Alan Pincus, *The DSM-IV Text Revision: Rationale and Potential Impact on Clinical Practice*, 53 PSYCHIATRIC SERV. 288 (2002).

cifically listed. This process has been summarized in the DSM-IV.¹¹³

Over one-thousand individuals helped prepare the DSM-IV. Thirteen work groups were created with liaisons to over sixty professional organizations interested in the content of the diagnostic manual. The National Institute of Mental Health sponsored twelve field trials encompassing over seventy research sites with more than 6,000 subjects participating. Significant research data were collected, but it was group consensus that led to ultimate decisions about which disorders were to be listed and how the diagnostic criteria were to be specified.¹¹⁴ Thus, while certain scientific evidence is required for a disorder's listing in the diagnostic manual, other issues impact the final product.¹¹⁵

An important consideration in the development and refinement of the nomenclature was the DSM-IV Task Force's position on new disorders: "We decided that, in general, new diagnoses should be included in the system only after research has established that they should be included."¹¹⁶

Because the literature on PAS was quite limited at the time that DSM-IV was under development, Gardner did not submit PAS for inclusion in the DSM-IV.¹¹⁷ Given the DSM-IV requirement that new disorders be included in the diagnostic manual only after an appropriate research base has been established, Gardner believes that sufficient literature now exists to support the inclusion of PAS in DSM-V, and he intends to submit PAS for proper consideration.¹¹⁸ The present author is unaware of any information as to whether PAS will in fact be listed as a specific disorder in the DSM-V.

¹¹³ See AM. PSYCHIATRIC ASS'N, *supra* note 90.

¹¹⁴ See *id.*

¹¹⁵ See Robert L. Spitzer, *DSM-III and the Politics-Science Dichotomy Syndrome: A Response to Thomas E. Schacht's "DSM-III and the Politics of Truth,"* 40 AM. PSYCHOL. 522 (1985).

¹¹⁶ AM. PSYCHIATRIC ASS'N, *supra* note 90, at XX.

¹¹⁷ Gardner, *supra* note 111.

¹¹⁸ *Id.*

VIII. Research on Parental Alienation Syndrome

To evaluate the research literature on PAS, it will first be necessary to discuss the nature of scientific investigation.¹¹⁹ This is particularly important because some have stated that PAS lacks an adequate scientific basis;¹²⁰ this conflicts with Gardner's view that there is now a sufficient PAS literature to support its inclusion in official diagnostic nomenclature.¹²¹ In the absence of professional consensus on this issue, controversy ensues.¹²² By exploring the nature of scientific investigation, one can then consider the literature specific to PAS with greater sophistication and thereby make an informed judgment about the state of that literature.

A. *The Nature of Research in Applied Fields*

Scientific research in applied fields such as medicine and psychology usually follows a relatively straightforward progression.¹²³ First, a practitioner notices a condition that has little scientific information about it or devises a novel idea about how to evaluate or treat a more commonly encountered problem. The practitioner engages in some preliminary investigation¹²⁴ of what has been observed, and then describes it in the professional literature.¹²⁵ Other practitioners subsequently learn of the origina-

¹¹⁹ The author's presentation of the nature of scientific investigation is deliberately simplistic; a more comprehensive coverage is beyond the scope of this manuscript, and not necessary for present purposes.

¹²⁰ See Lewis Zirotiannis, *Evidentiary Issues with Parental Alienation Syndrome*, 39 FAM. CT. REV. 334 (2001).

¹²¹ Gardner, *supra* note 111.

¹²² See e.g., Kathleen Coulborn Faller, *The Parental Alienation Syndrome: What Is It and What Data Support It?* 3 CHILD MALTREATMENT 100 (1998); Richard A. Gardner, *The Parental Alienation Syndrome: What Is It and What Data Support It?: Comment* 3 CHILD MALTREATMENT 309 (1998); Richard A. Gardner, *Response to Kelly/Johnston Article*, 17 SPEAK OUT FOR CHILD. 5 (2002); Joan B. Kelly & Janet R. Johnston, *A Reformulation of Parental Alienation Syndrome*, 39 FAM. CT. REV. 249 (2001).

¹²³ See Ira Daniel Turkat, *Issues in the Relationship Between Assessment and Treatment*, 10 J. PSYCHOPATHOLOGY BEHAV. 185 (1988).

¹²⁴ Such investigation could be purely theoretical.

¹²⁵ This may include the descriptive case study, the case theory report, the case theory investigation, the case treatment report and/or the case treatment investigation. See IRA DANIEL TURKAT, *supra* note 76.

tor's report(s) and begin their own explorations in their respective offices. Exploratory permutations begin to appear. As multiple reports converge in the literature, eventually a more controlled scientific investigation is initiated. If the results are positive, other controlled experiments are initiated. When a substantial body of scientific evidence has accrued, the meaning of this evidence is reviewed with an eye toward professional consensus about the hypothesis under examination.¹²⁶

The above description details how clinical science progresses from initial ideas.¹²⁷ If we were to consider the state of scientific knowledge about a particular phenomenon on a continuum, at one end of the continuum would be the *untested hypothesis* of a cause-effect relationship and at the other end would be the *thoroughly tested hypothesis*. To get from one end to the other, a series of research steps must be taken.

1. *Investigative Procedures*

The tools of research progression can be briefly summarized. First, *uncontrolled observations* of the phenomena of interest are collected. For example, a physician reports his or her observations of an unusual case. Or, a psychologist describes a case study of an existing disorder where a new theory emerged and led to development of a novel treatment approach.¹²⁸ Next, *controlled observations* of the phenomenon are undertaken. For example, a psychologist gives a group of patients two psychological tests and determines statistically the relationship between the test scores.

Both controlled and uncontrolled observations permit the investigation of hypothesized relationships between certain variables, but neither allow a scientific statement about cause and effect. Once multiple controlled and uncontrolled observations

¹²⁶ See, e.g., James C. Ballenger, Jonathan R. T. Davidson, Yves Lecrubier, David J. Nutt, Thomas D. Borkovec, Karl Rickels, Dan J. Stein, & Hans-Ulrich Wittchen, *Consensus Statement on Generalized Anxiety Disorder from the International Consensus Group on Depression and Anxiety*, 62 J. CLINICAL PSYCHIATRY 53 (2001); Thomas Ollendick & Ronald J. Prinz, *Editors' Comment: International Consensus Statement on Attention Deficit Hyperactivity Disorder (ADHD)*, 5 CLINICAL CHILD FAM. PSYCHOL. REV. 87 (2002).

¹²⁷ See TURKAT, *supra* note 76.

¹²⁸ See *id.*

are reported in the literature, and a hypothesis about the relation between two or more variables remains plausible, *experiments* are performed. In contrast to observations (controlled or uncontrolled), experiments are designed to *manipulate* conditions so that a cause-effect relationship can be determined scientifically. An example of a cause-effect relationship might be that certain parental behavior causes a child to detest the other parent unjustly.

In an experiment, tightly controlled conditions are imposed to allow strict comparisons while one or more variables are manipulated. For example, 150 anxiety patients are randomly assigned¹²⁹ to one of five groups to evaluate the effectiveness of a new medicine: group one receives no medication,¹³⁰ group two receives a sugar pill (placebo),¹³¹ group three receives a small dose of the medicine, group four receives a moderate dose of the medication, and group five receives a large medicinal dose.¹³² In addition, in each of the groups that receive a pill, half of the patients are told that the medication they are taking has been shown to be only mildly effective, whereas the other half of patients in each group are told that the medication they are taking has been shown to be highly effective.¹³³ In every other aspect of the study, each patient is treated exactly the same. As a result, statements can be made about cause and effect because actual conditions representing the hypothesized relationships have been manipulated and compared while all other conditions have been held constant.

¹²⁹ This is done to improve the likelihood that there is no difference between the subjects in the groups before experimental conditions are manipulated. In this way, any differences between the groups that emerge at the end of the experiment are more likely to be due to the experimenter's manipulations and not some characteristic difference that set the groups apart before the experimental conditions were manipulated.

¹³⁰ This is done to compare the manipulation of no treatment versus the other treatment groups.

¹³¹ This is done to compare the manipulation of taking a pill that should have no therapeutic value versus one that should have some therapeutic value.

¹³² This is done to compare the differential effectiveness of dose levels.

¹³³ This is done to compare the effect of manipulating the patients' expectancies about the effectiveness of the medicine they are taking.

2. *Inquiry Advancements*

When studies are published — whether observational (uncontrolled or controlled) or experimental — limitations from previously published work are usually addressed and overcome by instituting ever increasing refinements to seek a greater specification of knowledge about the hypothesis of interest. In other words, the “bar should rise” with each generation of reports in the literature on a particular topic. For example, early investigations of a treatment for AIDS began with one patient and then two. Eventually, the treatment was given to one group of patients and not another. Later, the treatment was compared to other treatments, and subsequent permutations of the treatment were applied to those individuals with certain AIDS characteristics (e.g., number of years suffering from the disease) and compared to those patients with other AIDS characteristics (e.g., number of years receiving a particular medication).

In sum, a simple understanding of the progression and quality of scientific information can be ascertained by observing the tools used in research: uncontrolled observations followed by controlled observations and then experiments. While observations are highly useful, only properly designed experiments permit statements about cause-effect relationships.

B. *Evaluating the Accumulation of Evidence*

With an understanding of the steps and procedures that characterize the development of knowledge in applied fields such as psychology and medicine, it is important to examine the level of progress in evidence accumulation. How can we evaluate the course of the accumulation of findings on a topic of interest? What is the natural history of a particular untested hypothesis that begins to undergo professional scrutiny? For present purposes, the author will attempt to describe several ways to evaluate the progress of knowledge accumulation about a clinical hypothesis¹³⁴ because it has direct implications for evaluating the PAS literature.

¹³⁴ The present author served for 15 years as the Associate Editor of the *Journal of Psychopathology and Behavioral Assessment*, a scientific and clinical peer-review journal.

1. *The Availability of Clinical Hypotheses*

Most clinical hypotheses never reach the stage of being studied by those who did not originate the hypothesis. In other words, mental health professionals frequently come up with untested ideas about their patients that typically will remain buried in the clinicians' offices, as most practitioners rarely publish.¹³⁵ Therefore, the mental health professional who publishes his or her clinical observations and hypotheses is part of an exclusive group of contributors to the field.

2. *The Reaction to New Clinical Hypotheses*

Many of the uncontrolled observations offered by practitioners that publish them go unnoticed by others. This may be due to several factors, such as the amount of information already available on a particular phenomenon (e.g., a well studied problem may be less influenced by a new clinical hypothesis), where the article was published, and the quality of the uncontrolled observation being offered. An uncontrolled observation of poor quality usually dies a rapid death in the literature.¹³⁶

In contrast, a useful observation is likely to become a topic of discussion by others. If the uncontrolled observation was not useful, few would spend time on it, and certainly not for long. Thus, if an uncontrolled observation begins to receive attention in the literature from others, that is usually a sign that the idea has some degree of merit.¹³⁷

3. *Beyond Uncontrolled Evaluations*

Clinical hypotheses that remain exclusively in the domain of practitioners' uncontrolled observations limit the potential con-

¹³⁵ See Colin Barrom, William Shadish & Linda Montgomery, *PhDs, PsyDs, and Real-World Constraints on Scholarly Activity: Another Look at the Boulder Model*, 19 *PROF. PSYCHOL.* 93 (1988).

¹³⁶ Although this may vary considerably; sometimes, an uncontrolled observation may go unnoticed for a lengthy period of time; subsequently, its quality becomes apparent. However, a poor quality observation is unlikely to offer much utility to others at any time.

¹³⁷ In science, an idea with merit is one that stimulates research, even if that idea eventually is rejected by scientific investigation. Naturally, the untested hypothesis that survives the progression of scientific inquiry is a more useful contribution.

tribution of those hypotheses to the field at large. Thus, a significant point in the fate of a clinical hypothesis occurs when controlled observations start to be reported in the literature — it suggests that knowledge is progressing. Having survived attacks on the hypothesis at the uncontrolled level, the idea appears to have sufficient merit to advance to more systematic data collection.

Next, when a clinical hypothesis becomes the focus of well controlled scientific experiments, the hypothesis of interest has made a definite contribution to the field. Clinicians do not have the resources to perform rigorous scientific experiments;¹³⁸ whereas, researchers do.¹³⁹ However, the number of researchers that have the wherewithal to perform controlled scientific experiments is far smaller than the number of practitioners that can generate untested clinical hypotheses. Given the limited resources, the idea that is studied experimentally has survived the “cut” in the sense that a determination has been made that it is worth investing considerable resources to evaluate the idea’s viability. Furthermore, the hypothesis properly studied experimentally has made a contribution no matter what the outcome: whether confirmed or not, scientific knowledge has developed about the viability of the idea. A hypothesis that has been rejected because of scientific data is a statement of greater knowledge than a hypothesis that has been rejected without the benefit of scientific inquiry.¹⁴⁰

Finally, when numerous research experiments provide data on a hypothesis, the field moves toward developing a consensus.¹⁴¹ Sometimes, that consensus may be that additional scientific data of a particular type is needed to support or reject the hypothesis; in other cases, confirmatory consensus or outright rejection develops from the scientific data. A good example is the body of literature that has accrued on the Rorschach, a widely

¹³⁸ See Ira Daniel Turkat & Stephen A. Maisto, *Application of the Experimental Method to the Formulation and Modification of Personality Disorders*, CLINICAL HANDBOOK OF PSYCHOL. DISORDERS 503 (David H. Barlow ed., 1985).

¹³⁹ See Turkat, *supra* note 76.

¹⁴⁰ A hypothesis, for example, that has been rejected purely for political reasons.

¹⁴¹ See William J. White, *A Communication Model of Conceptual Innovation in Science*, 11 COMMUNICATION THEORY 290 (2001).

used psychological test that has been studied in hundreds of investigations.¹⁴² Despite this, considerable disagreement exists today whether psychologists should use this test.¹⁴³

Scientific knowledge about a clinical hypothesis does not come from a few published reports. Rather, a substantial body of literature develops over many years to evaluate the utility of the hypothesis of interest. In many cases, it may take decades to develop a scientific consensus about a particular clinical hypothesis.

C. *The Nature of Research on Parental Alienation Syndrome*

How does PAS fare in regard to the development of scientific knowledge about Gardner's observations? This question can now be examined in light of the indicators of scientific knowledge progression just discussed.¹⁴⁴

First, Dr. Richard Gardner has made a substantial contribution to the clinical literature. He has published numerous articles and books on PAS that have stimulated many others to further investigate PAS.¹⁴⁵ Not only has he reported observational information¹⁴⁶ on PAS evaluation, treatment, and follow-up,¹⁴⁷ he has provided considerable theory about the pathogenesis of PAS.¹⁴⁸ Scientific research does not proceed without useful hypotheses.¹⁴⁹ Gardner has provided a wealth of useful hypotheses to

¹⁴² See John Hunsley & J. Michael Bailey, *The Clinical Utility of the Rorschach: Unfulfilled Promises and an Uncertain Future*, 11 PSYCHOL. ASSESSMENT 266 (1999); Gregory J. Meyer, *The Hard Science of Rorschach Research: What Do We Know and Where Do We Go?* 13 PSYCHOL. ASSESSMENT 486 (2001).

¹⁴³ See *id.*

¹⁴⁴ Considerable research has been conducted on topics that are related to PAS such as high-conflict divorce and attitude manipulation. However, these studies were not specifically addressing PAS as defined by Gardner, and thus are not included in the present discussion.

¹⁴⁵ Gardner, *supra* note 7.

¹⁴⁶ Gardner, *supra* note 6; but see, e.g., Rand, *supra* note 8.

¹⁴⁷ Richard A. Gardner, *Should Courts Order PAS Children to Visit/Reside with the Alienated Parent? A Follow-up Study*, 19 AM. J. FORENSIC PSYCHOL. 61 (2001).

¹⁴⁸ See Gardner, *supra* note 37.

¹⁴⁹ See Turkat, *supra* note 76.

the clinical literature.¹⁵⁰ In this regard, he has been an exemplary role model compared to other practitioners in the field.

Second, as literature on PAS occurs with increasing regularity,¹⁵¹ support for the utility of Gardner's clinical descriptions is provided. Similar to Gardner's contributions, the current literature, which is less than twenty-years old, consists primarily of clinical case reports, theoretical offerings, and other uncontrolled observations. As inquiries on PAS have begun to mature, controlled observations are now starting to appear.¹⁵² To date, the author is not aware of any experiments designed specifically to evaluate PAS,¹⁵³ in which key variables were tightly manipulated and measured under properly controlled comparison conditions,¹⁵⁴ or any field trials¹⁵⁵ that have been conducted to establish that PAS can be diagnosed in a reliable¹⁵⁶ and valid¹⁵⁷ manner. Thus, when viewed as a whole, one can conclude that the current literature on PAS reflects the natural progression one would expect to find when scientific understanding of a particular disorder begins to accrue. However, the fact that necessary scientific investigations have yet to be performed,¹⁵⁸ means that one cannot state with proper authority that PAS has been rejected or accepted by the scientific community.

¹⁵⁰ Mary Lund, *A Therapist's View of Parental Alienation Syndrome*, 33 *FAM. & CONCILIATION CTS. REV.* 308 (1995).

¹⁵¹ See Gardner, *supra* note 7.

¹⁵² See Jeffrey Siegel & Joseph Langford, *MMPI-2 Validity Scales and Suspected Parental Alienation Syndrome*, 16 *AM. J. FORENSIC PSYCHOL.* 5 (1998).

¹⁵³ In an experiment where PAS was clearly defined, diagnosed, and measured.

¹⁵⁴ See Cartwright, *supra* note 10, for the proposition that there is an absence of proper scientific data regarding the effects of PAS on the children involved.

¹⁵⁵ Similar to the DSM field trials.

¹⁵⁶ Numerous ways exist to consider the reliability of a diagnosis, but for present purposes, when different clinicians can independently agree at a high rate on the presence or absence of a particular disorder in the same group of patients, the diagnosis is considered to be reliable.

¹⁵⁷ Validity of a diagnosis is a complex subject, but here it refers to the accuracy of this phenomenon as representing a true diagnostic entity. In other words, what scientific evidence is there that PAS exists? Various types and methods exist to establish validity; numerous high quality research studies are required to establish a disorder's diagnostic validity.

¹⁵⁸ See Warshak, *supra* note 55.

D. *Impediments to Scientific Research on PAS*

Why has over a decade of reports in the literature on PAS failed to produce well controlled scientific investigations?

1. *The Pace of Research*

As noted above, the progression of scientific knowledge concerning applied phenomena involves varying degrees of investigation; many years are required to develop a full body of pertinent literature. This is true under the best of circumstances. Conversely, if conditions are not conducive to foster the accumulation of proper scientific data, the body of research literature grows at an even slower pace.

2. *Definitional Requirements*

For high quality research to proceed, one must have clear definitions.¹⁵⁹ Gardner has articulated eight criteria for diagnosing PAS,¹⁶⁰ but how many of these symptoms are needed for a PAS diagnosis, and which symptoms must be present?¹⁶¹ Without a uniform diagnostic criteria specification, different definitions of PAS could be used which would complicate the interpretation of data across different research studies.

3. *Measurement Requirements*

To perform quality research on PAS, one must have a reliable and valid method for its measure.¹⁶² This may take the form of a standardized questionnaire, structured interview, a rating scale or some other protocol that has been scientifically evaluated and supported. To date, no instrument in the literature has appeared that has been scientifically shown to be a reliable and valid method to assess PAS.¹⁶³ This is true not only for differen-

¹⁵⁹ See COMPREHENSIVE HANDBOOK OF PSYCHOPATHOLOGY (Henry E. Adams & Patricia B. Sutker eds., 1984).

¹⁶⁰ Gardner, *supra* note 7.

¹⁶¹ See Warshak, *supra* note 55.

¹⁶² See Anthony R. Ciminero, Karen S. Calhoun & Henry E. Adams, HANDBOOK OF BEHAV. ASSESSMENT (1977).

¹⁶³ See O'Leary, *supra* note 54.

tiating PAS from other disorders, but also for measuring the level of PAS symptomatology.¹⁶⁴

The scientific development of a reliable and valid psychological measure takes several years, and requires many research studies. The most widely used clinical assessment instrument in psychology, the Minnesota Multiphasic Personality Inventory (MMPI),¹⁶⁵ has fifty-years worth of scientific investigations behind it; despite this, scoring errors continue to occur,¹⁶⁶ and questions about its usefulness in assessing psychopathology remain.¹⁶⁷

4. *Terminological Practices*

Even when definitions are clearly specified, terminological confusion can still occur to hinder research advancement.¹⁶⁸ As Gardner has noted, some have confused the terms PA and PAS.¹⁶⁹ The problem is exacerbated when related phenomena are discussed as evidence for PAS or for some aspects (or derivative) of PAS.¹⁷⁰ For example, considerable scientific research exists in the areas of high conflict divorce,¹⁷¹ intense indoctrination,¹⁷² and methods of influence.¹⁷³ However, these bodies of research do not specifically categorize subjects according to the presence or absence of PAS as defined by Gardner, nor do they manipulate conditions to produce the set of behaviors specifically labeled and clustered as PAS. Thus, one cannot prop-

¹⁶⁴ The same observation applies to certain diagnostic categories in the DSM-IV.

¹⁶⁵ The current version is the MMPI-2.

¹⁶⁶ See David Faust & Gregory Allard, *Errors in Scoring Objective Personality Tests*, 7 *ASSESSMENT* 119 (2000).

¹⁶⁷ Edward Helmes & John R. Reddon, *A Perspective on Developments in Assessing Psychopathology: A Critical Review of the MMPI and MMPI—2*, 113 *PSYCHOL. BULL.* 453 (1993).

¹⁶⁸ See Turkat, *supra* note 86.

¹⁶⁹ See Gardner, *supra* note 67.

¹⁷⁰ See Warshak, *supra* note 55.

¹⁷¹ See Michael E. Lamb, Kathleen Sternberg & Ross A. Thompson, *The Effects of Divorce and Custody Arrangements on Children's Behavior, Development, and Adjustment*, 35 *FAM. & CONCILIATION CTS. REV.* 393 (1997).

¹⁷² See Robert Baron, *Arousal, Capacity, and Intense Indoctrination*, 4 *PERSONALITY & SOC. PSYCHOL. REV.* 238 (2000).

¹⁷³ See Daniel J. O'Keefe & Scott L. Hale, *An Odds-Ratio-Based-Meta-Analysis of Research on the Door-in-the-Face Influence Strategy*, 14 *COMMUNICATION REP.* 31 (2001).

erly utilize studies of this kind as scientific evidence supporting PAS as a distinct, reliable and valid diagnostic entity. Pointing to non-PAS research as directly supportive of PAS can muddle the literature. Similarly, some have attempted to “reformulate” PAS¹⁷⁴ or couch it within different conceptual frameworks.¹⁷⁵ While useful theoretical models are certainly to be encouraged, it is important that researchers not confuse the definition of PAS with that of a reformulation of it. As noted in research on other types of psychopathology, when investigators use different definitions while using similar diagnostic labels, the scientific literature becomes chaotic and the advancement of data based knowledge is inhibited.¹⁷⁶ Research on topics related to PAS can be quite useful but can never serve as an adequate substitute for inquiry specific to PAS.

5. Availability of Research Participants

One of the greatest impediments to scientific studies on PAS involves the availability of litigants to serve as participants in research investigations. Some psychiatric abnormalities are easier to study than others. For example, anxiety disorders are common and individuals regularly seek out treatment for them. Thus, a shortage of individuals to participate in research on anxiety is rare.¹⁷⁷ On the other hand, researchers interested in PAS are not as fortunate.

Most subjects in clinical research come from centers that treat psychiatric disorders (e.g., mental health clinics or hospitals) and/or from university departments of psychology and psychiatry. To the best of the author’s knowledge, there is no academic center for studying PAS or a well established clinic that specializes in treating large numbers of the disorder. PAS cases most often arise out of custody litigation;¹⁷⁸ by and large, courts are not set up to funnel potential PAS cases into standardized research protocols.

¹⁷⁴ See Kelly, *supra* note 122.

¹⁷⁵ See Joseph Price & Kerry Pioske, *Parental Alienation Syndrome: A Developmental Analysis of a Vulnerable Population*, 32 J. PSYCHOSOCIAL NURSING MENTAL HEALTH SERV. 9 (1994).

¹⁷⁶ See Turkat, *supra* note 86.

¹⁷⁷ Millions of individuals suffer from anxiety.

¹⁷⁸ See Gardner, *supra* note 4.

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Even if courts were to actively participate in forwarding cases into psychological research projects on PAS, numerous obstacles can arise. In addition to the diagnostic and assessment issues presented earlier, ethical problems should be considered. For example, subjects in psychological research participate primarily on a voluntary basis.¹⁷⁹ Individuals who have been accused of demonstrating PAS, but deny it, are probably not likely to volunteer to serve as subjects in a PAS experiment.¹⁸⁰

Scientific research also requires a relatively large number of available subjects. How prevalent is PAS? Gardner has indicated that he sees some PAS symptomatology in about ninety percent of custody cases that are litigated.¹⁸¹ That does not mean, however, that PAS is present in ninety-percent of custody litigation cases. Given that the number of symptoms required to diagnose PAS has yet to be determined scientifically, estimating the prevalence of PAS becomes difficult.¹⁸²

Another way to illustrate the difficulty in subject recruitment for research on PAS is to consider the commonality of custody litigation. One estimate suggested that 100,000 custody battles occur each year.¹⁸³ If this estimate is divided by the number of counties in the United States of America (N=3066),¹⁸⁴ then an average of thirty-three litigated custody disputes occur per county, per year.¹⁸⁵ More than likely, a significant number of these custody litigants do not experience PAS; this then cuts the number of available subjects even further. Taking into account other factors that might reduce the available research subject

¹⁷⁹ See AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT (1992).

¹⁸⁰ For example, volunteering as a research subject in a scientific study on PAS could be interpreted by some as evidence of the presence of PAS — this would be especially likely if the study only utilized subjects that met PAS criteria.

¹⁸¹ Gardner, *supra* note 37.

¹⁸² See O'Leary, *supra* note 54.

¹⁸³ See Ira Daniel Turkat, *Custody Battle Burnout*, 28 AM. J. FAM. THERAPY 201 (2000).

¹⁸⁴ This figure is from the National Association of Counties, <http://www.naco.org>.

¹⁸⁵ Given this as an estimated average, many counties would be likely to have more than thirty-three custody battles per year, and many would be likely to have less. Also, the 100,000 ball park figure could be incorrect.

pool (e.g., refusal to participate, need to study subjects at the same time), the investigator faces an uphill battle in procuring a sufficient cohort of PAS subjects to conduct high quality research.

Given the above impediments, one might understand why scientific research on PAS has not progressed as rapidly as one might like. To correct the situation efficiently, significant coordination between the judiciary and mental health researchers interested in PAS must take place.

E. *The Importance of Scientific Data on PAS*

In light of the obstacles to PAS research, the phenomenon remains a significant problem for the judiciary. Gardner has reported that sixty-six courts have recognized PAS.¹⁸⁶ Facing the dilemma of what to do when cases of this kind present in the courtroom,¹⁸⁷ Gardner has articulated treatment options for the judiciary to implement in pertinent PAS cases.¹⁸⁸

In some instances, Gardner advises that custody be switched from the alienating parent to the victimized one — a recommendation applied primarily to severe cases.¹⁸⁹ To support his position, Gardner has provided follow-up data on cases involving his treatment recommendations.¹⁹⁰ In those cases where he advocated a change in custody or access, the PAS diminished or resolved in one-hundred percent of cases when the courts followed his advice. Conversely, ninety-one percent of cases did not improve or deteriorated when Gardner's recommendations were not adopted.¹⁹¹

This report is particularly noteworthy. Few mental health professionals devise innovative treatments and even fewer perform follow-up analyses years later that contain percentage data on symptom outcome. Once again, Gardner has provided a use-

¹⁸⁶ Richard A. Gardner, *Comments on Carol S. Bruch's Article "Parental Alienation Syndrome and Parental Alienation: Getting it Wrong in Child Custody Cases,"* 35 FAM. L.Q. 553 (2001).

¹⁸⁷ A review of the literature on the standards for the admissibility of testimony on PAS is beyond the scope of the present manuscript.

¹⁸⁸ Gardner, *supra* note 50.

¹⁸⁹ *Id.*

¹⁹⁰ Gardner, *supra* note 147.

¹⁹¹ *Id.*

ful contribution. Further, the data reveal dramatic differences when Gardner's recommendations are accepted or rejected. Unfortunately, the study is plagued by numerous limitations, some of which Gardner has articulated.¹⁹² The present author is unaware of any scientific research designed exclusively to measure the effects of PAS intervention.

Given the adversarial nature of custody litigation, it is understandable why PAS and Gardner's proposed interventions for it would provoke controversy. A parent accused of unjustly alienating a child against the other parent is unlikely to welcome such an allegation. A litigant facing a PAS-based recommendation to give up custody is likely to contest it. Because there is an absence of pertinent scientific investigations to guide recommendations to the court, the room for argument and disagreement is enormous. Attacks on Gardner have come not only from the battles of specific litigation, but also from various advocacy groups.¹⁹³ In fact, Gardner has received so much attack from so many different sources that he recently was compelled to publish an article entitled, *Misinformation Versus Facts about the Contributions of Richard A. Gardner, M.D.*¹⁹⁴

Advocacy in the courtroom can certainly encourage adversarial interactions,¹⁹⁵ and emotionally charged custody litigation is well known for it.¹⁹⁶ When an allegation is made during the course of custody litigation where one parent may be unjustly alienating the other parent, and such an allegation has implications for the placement of the children, it would be surprising if Gardner was *not* attacked in some manner.

If one attorney charges that the opposing client is displaying PAS, that litigant's counsel may counter that no scientific evidence supports the existence of the syndrome.¹⁹⁷ If the court believes that PAS is occurring in a particular case, arguments may

¹⁹² *Id.*

¹⁹³ John Dunne & Marsha Hedrick, *The Parental Alienation Syndrome: An Analysis of Sixteen Selected Cases*, 21 J. DIVORCE & REMARRIAGE 21 (1994).

¹⁹⁴ Richard A. Gardner, *Misinformation Versus Facts About the Contributions of Richard A. Gardner, M.D.*, 30 AM. J. FAM. THERAPY. 395 (2002).

¹⁹⁵ See LENARD MARLOW & S. RICHARD SAUBER, *THE HANDBOOK OF DIVORCE MEDIATION* (1990).

¹⁹⁶ See Turkat, *supra* note 183.

¹⁹⁷ See Cheri L. Wood, *The Parental Alienation Syndrome: A Dangerous Aura of Reliability*, 27 LOYOLA. L.A. L. REV. 1367 (1994).

be presented for both the viability of Gardner's treatment recommendations,¹⁹⁸ as well as the lack of professional consensus about them.¹⁹⁹ While one lawyer may point to Gardner's academic credentials,²⁰⁰ opposing counsel may offer evidence alleging Gardner is sexist.²⁰¹ Whether discussing false allegations of abuse or actual domestic violence, some consider PAS as helpful,²⁰² while others view it as dangerous.²⁰³ Positions for²⁰⁴ and against Gardner²⁰⁵ are in no short supply.²⁰⁶

In the end, good science is needed to resolve the quandary in which many judges find themselves when it comes to PAS. The reason is quite simple: until proper scientific evidence is generated, the judiciary will be forced to rely upon the opinions of various mental health professionals. Since these opinions can be highly discrepant, PAS will continue to provoke considerable controversy in the foreseeable future.

IX. Management of PAS

In light of the stage of research progression that characterizes PAS, the court must balance that literature with the practical needs of the presenting case. How should the judiciary respond when an allegation of PAS is placed before it? In this section, the present author will attempt to provide some useful guidelines.²⁰⁷

¹⁹⁸ See Dunne, *supra* note 193.

¹⁹⁹ See Warshak, *supra* note 55.

²⁰⁰ Clinical Professor of Child Psychiatry at Columbia University College of Physicians and Surgeons.

²⁰¹ See Gardner, *supra* note 194. Based on Dr. Gardner's writings, the present author does not believe that Dr. Gardner is sexist. See also Gardner, *supra* note 111.

²⁰² Douglas Darnell, *Parental Alienation: Not in the Best Interest of the Children*, 75 NOTRE DAME L. REV. 323 (1999).

²⁰³ See Ruth Busch, Leslie Drozd, Toby Kleinman, & Stephanie Dallam, *Parental Alienation Syndrome: Its Dangerous Use Internationally in CT. Cases Involving Family Violence*, Pre-Conference Workshop presented Sept. 25, 2002, at the Family Violence and Sexual Assault Institute.

²⁰⁴ See Walsh & Bone, *supra* note 1.

²⁰⁵ See Carol S. Bruch, *Parental Alienation Syndrome and Parental Alienation: Getting it Wrong in Child Custody Cases*, 35 FAM. L.Q. 527 (2001).

²⁰⁶ See Warshak, *supra* note 55.

²⁰⁷ Given space limitations, the present manuscript does not address the potential advantages and disadvantages of mediation in regard to disputes involving PAS.

It is recognized that no scientific study has been performed on these recommendations. However, the same criticism holds true for the recommendations offered in most psychological custody evaluation reports. To date, the author is not aware of a scientific study²⁰⁸ that has demonstrated that the child placement recommendations of a psychologist yields an objectively determined better outcome for the children involved in custody litigation, as compared to the opposite recommendation or to no recommendation.

In considering the management of PAS, it is instructive to keep in mind that the DSM-IV specifically states that not all mental disorders are listed in the current diagnostic manual.²⁰⁹ The DSM-IV fully recognized that some conditions require psychiatric interventions that are not listed by name in the nomenclature.²¹⁰ The utility of this position can be seen historically: there was a time when AIDS was not listed as a medical disorder,²¹¹ yet patients presented with the disease and received treatment *before* the scientific body of research progressed to a consensus.

The key issue in custody litigation is to determine what is in the best interest of the child. If a serious allegation of PAS is made, it should be investigated. Just as an allegation of sexual abuse is taken with the utmost concern (despite the lack of professional agreement on a definition of child sexual abuse),²¹² so too should an allegation of abuse based on unjust alienation of a child against his or her parent. How then should this concern be approached?

A. *Recommendations for the Judiciary*

First, the court must be made aware of PAS. If one does not understand PAS well, it would be difficult to evaluate a PAS allegation. In pertinent circumstances, an expert may need to testify to educate the court. Ideally, this should be someone who is not

²⁰⁸ With proper experimental design to allow a strong inference about cause and effect.

²⁰⁹ See AM. PSYCHIATRIC ASS'N, *supra* note 90.

²¹⁰ See *id.*

²¹¹ See Gardner, *supra* note 7.

²¹² See Jeffrey J. Haugaard, *The Challenge of Defining Child Sexual Abuse*, 55 AM. PSYCHOL. 1036 (2000).

only an authority on PAS, but has virtually no knowledge of the presenting case and sees his or her role merely as serving as a neutral educational resource.

Second, the court must evaluate the current evidence for the PAS allegation. Should any information emerge that lends reasonable support to the allegation, the court should order an appropriate psychological evaluation of the parties. This examination should be performed by a psychologist or psychiatrist with the following minimal characteristics:

1. *Has Never Had Contact With the Litigants or Their Children*

The reason for this is simple: the evaluator should be free of any potential allegiance or bias toward any of the parties involved. When a therapist takes on a case, he or she is agreeing to be helpful to that client. When external inquiries are made about the client or attacks are brought upon the client, the therapist's supportive efforts will typically include becoming an advocate for the client.²¹³ Such a relationship is likely to color how that mental health professional views events that pertain to his or her client. The American Psychological Association (APA) recognized the threat to a therapist's integrity by serving in dual relationships (e.g., as therapist to one litigant and evaluator of both litigants), and warned that improper relationships of this kind violated the APA ethical code.²¹⁴

2. *Has Documented Knowledge of PAS*

The DSM-IV lists hundreds of mental disorders.²¹⁵ No psychologist, therefore, can be expert concerning them all. If confronted with a violent and actively psychotic²¹⁶ mental patient, the court would be ill advised to seek out a psychologist who specializes in treating the study habit problems of college students. Instead, a mental health practitioner with considerable ex-

²¹³ See Grant L. Iverson, *Dual Relationships in Psycholegal Evaluations: Treating Psychologists Serving as Expert Witnesses*, 18 AM. J. FORENSIC PSYCHOL. 79 (2000).

²¹⁴ See AM. PSYCHOL. ASS'N, *supra* note 179.

²¹⁵ See AM. PSYCHIATRIC ASS'N, *supra* note 90.

²¹⁶ The term "psychotic" is used here to mean being out of touch with reality and experiencing serious hallucinations or delusions.

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perience with violent psychotics would be the clinician of choice. The overwhelming majority of psychologists have no experience with PAS;²¹⁷ such individuals would be at a distinct disadvantage in evaluating a case where PAS was an issue.

3. *Believes That Cases of PAS Exist*

A mental health practitioner who does not believe that PAS exists runs the risk of making a false negative diagnostic error (i.e., claims that PAS is not present when in fact it is). Having a psychologist, who does not believe that PAS exists, evaluate a family for the presence or absence of PAS limits the court's ability to assist that family if indeed a PAS is present. For this reason, the court should be aware of the mental health practitioner's opinions on the existence of PAS *before* ordering such a person to perform an evaluation of this kind.

4. *Believes That Cases Involving False Allegations of PAS Exist*

A psychologist who believes that false allegations of PAS are not made runs the risk of making a false positive diagnostic error (i.e., claims that a PAS is present when it is not). In order for a mental health professional to properly evaluate whether PAS is present in a particular family, he or she must believe that cases can occur where PAS exists, and those where PAS is falsely alleged.

5. *Can Articulate Obstacles to Effective Treatment in PAS Cases*

Successful treatment of an individual presenting psychopathology begins with a formulation of the case.²¹⁸ A proper case formulation outlines (among other things) the expected obstacles to successful intervention.²¹⁹ Without a priori specification of likely pitfalls, the prognosis may depreciate because effective treatment must manage those factors that interfere with a successful outcome. This point is especially important given the ab-

²¹⁷ This is due to several factors, most notably, that only a very small percentage of psychologists perform custody litigation-related work.

²¹⁸ See IRA DANIEL TURKAT, *BEHAV. CASE FORMULATION* (1985).

²¹⁹ See IRA DANIEL TURKAT, *The Behavioral Interview*, *HANDBOOK OF BEHAV. ASSESSMENT* (Anthony R. Ciminero et al. eds., 2d ed. 1986).

sence of scientific guidelines to direct intervention with a PAS case.²²⁰ If a mental health practitioner cannot identify the obstacles that are likely to appear in treating a particular case of PAS, he or she may be at an increased risk for recommending an inadequate therapeutic regimen. Prior experience with PAS cases facilitates identification of common intervention pitfalls.

6. *Has a Strong Background in Adult Psychopathology*

Given that PAS cannot exist without the training efforts of a parent,²²¹ a psychologist with a weak background in adult psychopathology would likely be at a disadvantage in evaluating the parents. Failure to formulate *why* a particular parent may be instituting unjust alienation in his or her children reduces the likelihood of devising a treatment recommendation that will address the factors causing the problem in the first place.

7. *Has a Strong Background in Child Development*

To properly evaluate the children in a family where PAS may be operating, the mental health professional should have a firm foundation in pertinent child development issues. For example, research on high conflict divorce indicates that children at varying ages react differently to the hostility demonstrated by their parents.²²² A young child may be more susceptible to align with whichever parent he or she is with.²²³ Similarly, it is common for children at certain ages to display separation anxiety from the primary caretaker²²⁴ and parents who experience their own separation anxiety from their offspring may display certain personality attributes.²²⁵ Failure to appreciate such findings may lead to diagnostic and/or treatment recommendation errors when evaluating a family with a PAS allegation.

²²⁰ Gardner has provided guidelines on the treatment of PAS according to the type of case presented, but comprehensive scientific experiments on intervention efficacy have yet to be performed.

²²¹ Parents are the typical alienator.

²²² See Rand, *supra* note 8.

²²³ See *id.*

²²⁴ See James H. Beeghly, *Anxiety and Anxiety Disorder in Childhood*, 32 NEW DIRECTIONS MENTAL HEALTH SERV. 57 (1986).

²²⁵ See Ellen Hock & Wilma J. Lutz, *Psychological Meaning of Separation Anxiety in Mothers and Fathers*, 12 J. FAM. PSYCHOL. 41 (1998).

8. *Is Willing to Consult a PAS Expert, if Needed*

In some cases, a mental health professional may require assistance in evaluating a family where PAS may be present. In those instances, a clinician should consult with a PAS expert. A mental health practitioner who would be unwilling to consult an expert when needed is in violation of the APA ethical code.²²⁶

9. *Agrees to Provide an Evaluation of the Presence or Absence of PAS Along with a Recommendation for Action by the Court and to Limit His or Her Involvement as Such*

If a judge is concerned that a PAS may be present in a particular case, referral to a pertinent professional for an evaluation of that specific issue should be ordered. The scope of the evaluation should be limited to the aforementioned issue as well as specification of a recommended course of intervention.²²⁷ The major advantage of not permitting the PAS evaluator to provide additional services to the family is that it discourages the mental health professional from engaging in multiple roles; this helps to protect both the family (from recommendations that may not be based “purely” on the indicants of the evaluation) and the psychologist (from violating the ethical code issued by the APA regarding such relationships).²²⁸ Finally, should it be determined that a PAS is present and that intervention is necessary, a different psychologist or psychiatrist should be appointed. This individual should have documented expertise in treating PAS cases.²²⁹

²²⁶ See AM. PSYCHOL. ASS'N, *supra* note 179.

²²⁷ In certain circumstances, this could include a recommendation for no intervention.

²²⁸ See AM. PSYCHOL. ASS'N, *supra* note 179.

²²⁹ Proper recommendations for intervention cannot be made at this time in light of the absence of comprehensive scientific data on treatment efficacy. Thus, the formulation of the particular clinical case should determine the intervention plan. For ideas on potential therapeutic efforts, Gardner's publications should be consulted.

B. *Problems with Implementing Recommendations for the Judiciary*

The above articulated recommendations have several drawbacks. The most striking obstacle may be the availability of pertinent expertise. Not all communities have PAS experts; therefore, a coordinated effort to raise the standards among local psychologists and psychiatrists should be pursued.

Another consideration is that as advocated herein, determination of the presence or absence of PAS is a separate evaluation process from a custody evaluation, although some overlap may occur (e.g., the PAS determination may lead to a recommendation pertinent to custody, and a custody evaluation may point to the presence or absence of PAS). Keeping these evaluations separate reduces the likelihood of the psychologist falling into dual roles, which may negatively affect his or her judgment.²³⁰ However, it may provide a heavier burden on the litigants and their children, and in some cases, the clinicians in the community that perform this type of work.

Expense is an additional drawback. A national survey published in 2001 determined that the average custody evaluation costs \$3,335, with the range of \$600 to \$15,000 for a couple with two children.²³¹ The typical cost for a PAS evaluation is unknown.

Psychological treatment of the PAS case remains a major source of concern. While Gardner has articulated a variety of intervention options for each of the three types of PAS,²³² the requisite scientific experiments to evaluate treatment effectiveness have yet to appear.²³³ Thus, intervention guidelines based on sound scientific data are unavailable to the judiciary, leaving it especially vulnerable to the biases of the mental health professionals involved in particular PAS cases.

²³⁰ See AM. PSYCHOL. ASS'N, *supra* note 179.

²³¹ See James N. Bow & Francella A. Quinnell, *Psychologists' Current Practices and Procedures in Child Custody Evaluations Five Years After American Psychological Association Guidelines*, 32 PROF. PSYCHOL. 261 (2001).

²³² See Gardner, *supra* note 50.

²³³ See Warshak, *supra* note 55.

Finally, incompetent mental health practitioners are not uncommon in custody litigation,²³⁴ and even the most talented and experienced psychologist can make mistakes. Such errors can take many forms. Diagnostically, one may conclude that PAS is present when it is not (a false positive diagnostic error) or that PAS is not present when in fact it is (a false negative diagnostic error). Similarly, incorrect treatment prescriptions can occur as can faulty intervention executions.²³⁵ Attorney complaints about mental health professionals' ineptitude in dealing with cases of PAS have been reported.²³⁶ Given the current state of the scientific literature on PAS, one should expect diagnostic and treatment errors to occur. Unfortunately, these mistakes can exacerbate the difficulties already being experienced by suffering families.

C. *Difficulties Confronting Trial Attorneys*

In addition to the problems listed above, trial lawyers face other areas of concern when dealing with PAS cases. This is true whether defending a client falsely accused of perpetuating unjust alienation, assisting a client suffering at the hands of the other parent who is inappropriately alienating their mutual offspring, or representing a client who is instituting a PAS.

1. *Conflicting Goals*

A major difficulty occurs when the litigant faces a conflict in goals. For example, a custody litigant targeted for unjust alienation has evidence about the alienator that the other side is unaware of that could be quite useful if presented in the courtroom at a maximally opportune moment. At the same time, the litigant is about to participate in a court ordered psychological evaluation of each family member. Given that whatever information provided to the evaluator is likely to be discovered by opposing counsel, the trial lawyer must determine whether to advise the

²³⁴ See Ira Daniel Turkat, *Questioning the Mental Health Expert's Custody Report*, 7 AM. J. FAM. L. 175 (1993).

²³⁵ See Turkat, *supra* note 123.

²³⁶ Kenneth Byrne, *Brainwashing in Custody Cases: The Parental Alienation Syndrome*, 4 AUSTL. FAM. L. 1 (1989).

client to present the evidence to the psychologist or withhold the information for a more potent “punch” in the courtroom.²³⁷

As another example, it is not uncommon for a client in a PAS case to be in need of psychological assistance. However, in certain situations, the attorney may determine that taking such a step could hurt the litigation effort. At times, the conflict between the goals of litigation success and immediately removing the client’s psychological distress may not permit a solution satisfactory to each concern.

The examples above illustrate that strategic and tactical decisions in complex PAS litigation should be made with the benefit of considerable “brain power.” Determinations based on inadequate analyses could generate significant damage, some of which may be irreparable.

2. Problems Created by Mental Health Professionals

Even when the trial lawyer believes that a mental health practitioner should assist a client suffering in a PAS case, it should be noted that not one scientific study²³⁸ has appeared showing that such a client can be treated successfully. At the clinical level, PAS children taken to mental health professionals often do not receive the help they need.²³⁹ Gardner has pointed out that some therapists could actually be damaging to individuals with PAS issues.²⁴⁰ Iatrogenic effects from psychotherapy in general are common.²⁴¹ Thus, the attorney attempting to assist a client by making a referral to a mental health practitioner in certain PAS cases may unwittingly be causing the client even more problems.

Another troubling issue confronting trial attorneys dealing with certain mental health professionals in a PAS case concerns the tremendous variability in how clinicians interpret informa-

²³⁷ From the psychologist’s viewpoint, the validity of the clinical evaluation may be threatened if important information is withheld.

²³⁸ Specifically PAS related with proper scientific design to allow a strong inference about cause and effect.

²³⁹ See Leona M. Kopetski, *Identifying Cases of Parental Alienation Syndrome—Part II*, 27 COLO. LAW. 63 (1998).

²⁴⁰ See Gardner, *supra* note 147.

²⁴¹ DANIEL T. MAYS & CYRIL M. FRANKS, *NEGATIVE OUTCOMES IN PSYCHOTHERAPY* (1985).

tion. For example, a psychologist reviewing an (unjustly) alienating parent's letter, in which the children state they hate the targeted parent and refuse visitation, may utilize that document to support a recommendation for a change in custody. In comparison, another practitioner may gloss over the letter; and under questioning, downgrade its importance by citing it as one "issue" among many that the family needs to address. As noted, "what one mental health expert might see as critical, another similarly trained professional might see as trivial. This leaves the court in a terrible quandary — one of which the court, at times, may not even be aware."²⁴² The attorney seeking competent psychological assessment or treatment of PAS related behavior, may find on occasion an experience that feels more like a crapshoot.

Finally, the way in which certain mental health professionals use diagnostic terms may cause additional difficulties. For example, despite the fact that the DSM-IV is almost universally accepted, some believe that the use of diagnostic labels stigmatizes those so labeled.²⁴³ Concern about misuse of the PAS label has led some mental health practitioners to prefer to speak of PA instead of PAS.²⁴⁴ Clearly, a bias of this kind may significantly affect the impact of a particular mental health professional's testimony. The litigator unprepared to explore this issue prophylactically may later find its management more troublesome.

X. Conclusion

In 1962, Eitinger reported on clinical symptoms observed in concentration camp survivors fifteen years following their detention.²⁴⁵ He called the constellation of symptoms: Concentration Camp Syndrome. No DSM diagnostic category specifically labeled as such existed. Despite this, individuals suffering with

²⁴² Turkat, *supra* note 234.

²⁴³ See Stephanie Cormack & Adrian Furnham, *Psychiatric Labelling, Sex Role Stereotypes and Beliefs About the Mentally Ill*, 44 INT'L J. SOC. PSYCHIATRY 235 (1998).

²⁴⁴ See Warshak, *supra* note 55.

²⁴⁵ Leo Eitinger, *Concentration Camp Survivors in the Postwar World*, 34 AM. J. ORTHOPSYCHIATRY 367 (1962).

Concentration Camp Syndrome received psychological intervention.²⁴⁶

Today, the DSM-IV specifies criteria for a disorder known as Posttraumatic Stress Disorder.²⁴⁷ The criteria are based on Eitinger's original description of Concentration Camp Syndrome.²⁴⁸ As a precursor to the current diagnostic category of Posttraumatic Stress Disorder,²⁴⁹ Eitinger's clinical descriptions set the course for a progression of observational and experimental reports that mark a body of current scientific information about Posttraumatic Stress Disorder.²⁵⁰ Eitinger's pioneering description is 40 years-old.²⁵¹

It remains to be seen if Gardner's 1985 description of PAS²⁵² will share a fate similar to Eitinger's Concentration Camp Syndrome. At the moment, PAS has been the subject of over 100 professional manuscripts.²⁵³ The syndrome will be submitted for inclusion in the DSM-V.²⁵⁴ It will be instructive to see in year 2025 (the 40th anniversary of Gardner's introduction of PAS) whether a significant body of scientific literature on PAS has developed, similar to Posttraumatic Stress Disorder.

Even if Gardner's goal of PAS being included as a specific category in DSM-V is achieved, this does not cement its standing in official psychiatric nomenclature. For example, the Passive Aggressive Personality Disorder²⁵⁵ has been discussed clinically in the literature for decades.²⁵⁶ It was incorporated as an official

²⁴⁶ See Leo Eitinger, *Studies on Concentration Camp Survivors: The Norwegian and Global Contexts*, 6 J. PSYCHOL. & JUDIASM 23 (1981).

²⁴⁷ See AM. PSYCHIATRIC ASS'N, *supra* note 90.

²⁴⁸ See Anna B. Baranowsky, Marta Young, Sue Johnson-Douglas, Lyn Williams-Keeler & Michael McCarrey *PTSD Transmission: A Review of Secondary Traumatization in Holocaust Survivor Families*, 39 CAN. PSYCHOL. 247 (1998).

²⁴⁹ See *id.*

²⁵⁰ Edna B. Foa, Richard Zinbarg & Barbara Olatosov Rothbaum, *Uncontrollability and Unpredictability in Post-Traumatic Stress Disorder: An Animal Model*, 112 PSYCHOL. BULL. 218 (1992).

²⁵¹ See Eitinger, *supra* note 195.

²⁵² See Gardner, *supra* note 6.

²⁵³ See Gardner, *supra* note 7.

²⁵⁴ See Gardner, *supra* note 111.

²⁵⁵ See AM. PSYCHIATRIC ASS'N, *supra* note 105.

²⁵⁶ See Turkat, *supra* note 86.

category of psychiatric disorder in several DSM editions,²⁵⁷ as recently as 1987 in DSM-III-R.²⁵⁸ However, the DSM-IV removed it as an official disorder in 1994.²⁵⁹ Unlike Concentration Camp Syndrome,²⁶⁰ the research literature did not emerge to mandate retaining Passive Aggressive Personality Disorder in the current nosology of mental disorders.²⁶¹ Thus, the fate of PAS as a diagnostic entity — like other disorders, will depend on the future accumulation of scientific findings.

One of the most important steps for elevating the sophistication of investigations into PAS is the development of a standardized method in diagnosing such cases which has ample scientific support.²⁶² An objective instrument with sound scientific data behind it offers the opportunity to improve the likelihood that clinicians and researchers are studying the same thing when the term PAS is used. This enables scientific information to develop more rapidly. Such information is necessary for the mental health professions to offer sound data based recommendations to the judiciary about individuals who may be demonstrating PAS.

Until the proper scientific research is completed, PAS will remain a clinical entity that appears to represent a bona fide psychiatric disorder that cannot be confirmed or disconfirmed by the present state of the scientific literature. With such a status, PAS will continue to invite considerable debate in the family law arena and leave families needing proper intervention to tangle with the biases of various mental health practitioners.

²⁵⁷ See Turkat, *supra* note 76.

²⁵⁸ See AM. PSYCHIATRIC ASS'N, *supra* note 105.

²⁵⁹ See *id.* at *supra* note 90.

²⁶⁰ Under the title Posttraumatic Stress Disorder.

²⁶¹ See AM. PSYCHIATRIC ASS'N, *supra* note 90.

²⁶² See O'Leary, *supra* note 54.