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Does DSM-IV Have Equivalents for the Parental Alienation Syndrome (PAS) Diagnosis?

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Child custody evaluators commonly find themselves confronted with resistance when they attempt to use the term parental alienation syndrome (PAS) in courts of law. Although convinced that the patient being evaluated suffers with the disorder, they often find that the attorneys who represent alienated parents, although agreeing with the diagnosis, will discourage use of the term in the evaluators' reports and testimony. Most often, they will request that the evaluator merely use the term parental alienation (PA). On occasion they will ask whether other DSM-IV diagnoses may be applicable. The purpose of this article is to elucidate the reasons for the reluctance to use the PAS diagnosis and the applicability of PA as well as current DSM-IV substitute diagnoses.

Mental health professionals, family law attorneys, and judges are generally in agreement that in recent years we have seen a disorder in which one parent alienates the child against the other parent. This problem is especially common in the context of child-custody disputes where such programming enables the indoctrinating parent to gain leverage in the court of law. There is significant controversy, however, regarding the term to use for this phenomenon. In 1985 I introduced the term parental alienation syndrome to describe this phenomenon (Gardner, 1985a).

The Parental Alienation Syndrome

In association with this burgeoning of child-custody litigation, we have witnessed a dramatic increase in the frequency of a disorder rarely seen previously, a disorder that I refer to as the *parental alienation syndrome* (PAS). In this disorder we see not only programming ("brainwashing") of the child by one parent to denigrate the other parent, but self-created contributions by the child in support of the alienating parent's campaign of denigration against the alienated parent. Because of the child's contribution I did not consider the terms *brainwashing*, *programming*, or other equivalent words to be sufficient. Furthermore, I observed a cluster of symptoms that typically appear together, a cluster that warranted the designation *syndrome*. Accordingly, I introduced the term *parental alienation syndrome* to encompass the *combination* of these two contributing factors that contributed to the development of the syndrome (Gardner, 1985a). In accordance with this use of the term I suggest this definition of the parental alienation syndrome:

The parental alienation syndrome (PAS) is a childhood disorder that arises almost exclusively in the context of child-custody disputes. Its primary manifestation is the child's campaign of denigration against a parent, a campaign that has no justification. It results from the combination of a programming (brainwashing) parent's indoctrinations and the child's own contributions to the vilification of the target parent. When true parental

abuse and/or neglect is present, the child's animosity may be justified and so the parental alienation syndrome explanation for the child's hostility is not applicable.

It is important to note that indoctrinating a PAS into a child is a form of abuse—emotional abuse—because it can reasonably result in progressive attenuation of the psychological bond between the child and a loving parent. In many cases it can result in total destruction of that bond, with lifelong alienation. In some cases, then, it may be even worse than other forms of abuse, e.g., physical abuse, sexual abuse, and neglect. A parent who demonstrates such reprehensible behavior has a serious parenting defect, their professions of exemplary parenting notwithstanding. Typically, they are so intent on destroying the bond between the child and the alienated parent that they blind themselves to the formidable psychological consequences on the child of their PAS indoctrinations, both at the time of the indoctrinations and in the future.

Most evaluators, family law attorneys, and judges recognize that such programming and child alienation is common in the context of child-custody disputes. They agree, also, that there are situations in which the child's alienation is the result of parental programming. Some object to the use of the term syndrome and claim that it is not a syndrome, but that the term parental alienation (PA) should be used. The problem with the use of the term PA is that there are many reasons why a child might be alienated from parents, reasons having nothing to do with programming. A child might be alienated from a parent because of parental abuse of the child, e.g., physical, emotional, or sexual. A child might be alienated because of parental neglect. Children with conduct disorders are often alienated from their parents, and adolescents commonly go through phases of alienation. The PAS is well viewed as one subtype of parental alienation. Accordingly, substituting the term PA for PAS cannot but cause confusion.

Is the PAS a True Syndrome?

Some who prefer to use the term *parental alienation* (PA) claim that the PAS is not really a syndrome. This position is especially seen in courts of law in the context of child-custody disputes. A syndrome, by medical definition, is a cluster of symptoms, occurring together, that characterize a specific disease. The symptoms, although seemingly disparate, warrant being grouped together because of a common etiology or basic underlying cause. Furthermore, there is a consistency with regard to such a cluster in that most (if not all) of the symptoms appear together. The term *syndrome* is more specific than the related term *disease*. A disease is usually a more general term, because there can be many causes of a particular disease. For example, pneumonia is a disease, but there are many types of pneumonia—e.g., pneumococcal pneumonia and bronchopneumonia—each of which has more specific symptoms, and each of which could reasonably be considered a syndrome (although common usage may not utilize the term).

The syndrome has a purity because most (if not all) of the symptoms in the cluster predictably manifest themselves together as a group. Often, the symptoms appear to be unrelated, but they actually are because they usually have a common etiology. An example would be Down's Syndrome, which includes a host of seemingly disparate symptoms that do not appear to have a common link. These include mental retardation, Mongoloid faces, drooping lips, slanting eyes, short fifth finger, and atypical creases in the palms of the hands. Down's Syndrome patients often look very much alike and most typically exhibit all these symptoms. The common etiology of these disparate symptoms relates to a specific chromosomal abnormality. It is this genetic factor that is responsible for linking together these seemingly disparate symptoms. There is then a primary, basic cause of Down's Syndrome: a genetic abnormality.

Similarly, the PAS is characterized by a cluster of symptoms that usually appear together in the child, especially in the moderate and severe types. These include:

1. A campaign of denigration
2. Weak, absurd, or frivolous rationalizations for the deprecation
3. Lack of ambivalence
4. The "independent-thinker" phenomenon
5. Reflexive support of the alienating parent in the parental conflict
6. Absence of guilt over cruelty to and/or exploitation of the alienated parent
7. The presence of borrowed scenarios
8. Spread of the animosity to the friends and/or extended family of the alienated parent

Typically, children who suffer with PAS will exhibit most (if not all) of these symptoms. However, in the mild cases one might not see all eight symptoms. When mild cases progress to moderate or severe, it is highly likely that most (if not all) of the symptoms will be present. This consistency results in PAS children resembling one another. It is because of these considerations that the PAS is a relatively "pure" diagnosis that can easily be made. Because of this purity, the PAS lends itself well to research studies because the population to be studied can usually be easily identified. Furthermore, I am confident that this purity will be verified by future interrater reliability studies. In contrast, children subsumed under the rubric PA are not likely to lend themselves well to research studies because of the wide variety of disorders to which it can refer, e.g., physical abuse, sexual abuse, neglect, and defective parenting. As is true of other syndromes, there is in the PAS a specific underlying cause: programming by an alienating parent in conjunction with additional contributions by the programmed child. It is for these reasons that PAS is indeed a syndrome, and it is a syndrome by the best medical definition of the term.

In contrast, PA is not a syndrome and has no specific underlying cause. Nor do the proponents of the term PA claim that it is a syndrome. Actually, PA can be viewed as a group of syndromes, which share in common the phenomenon of the child's alienation from a parent. To refer to PA as a group of syndromes would, by necessity, lead to the conclusion that the PAS is one of the syndromes subsumed under the PA rubric and would thereby weaken the argument of those who claim that PAS is not a syndrome.

The PAS and DSM-IV

There are some, especially adversaries in child-custody disputes, who claim that there is no such entity as the PAS. This position is especially likely to be taken by legal and mental health professionals who are supporting the position of someone who is clearly a PAS programmer. The main argument given to justify this position is that the PAS does not appear in DSM-IV. To say that PAS does not exist because it is not listed in DSM-IV is like saying in 1980 that AIDS (Autoimmune Deficiency Syndrome) did not exist because it was not then listed in standard diagnostic medical textbooks. DSM-IV was published in 1994. From 1991 to 1993, when DSM committees were meeting to consider the inclusion of additional disorders, there were too few articles in the literature to warrant submission of the PAS for consideration. That is no longer the case. It is my

understanding that committees will begin to meet for the next edition of the DSM (probably to be called DSM-V) in 2002 or 2003. Considering the fact that there are now at least 133 articles in peer-review journals on the PAS, it is highly likely that by that time there will be even more articles. (A list of peer-reviewed PAS articles is to be found on my website, www.rgardner.com/refs, a list that is continually being updated.)

It is important to note that DSM-IV does not frivolously accept every new proposal. Their requirements are very stringent with regard to the inclusion of newly described clinical entities. The committees require many years of research and numerous publications in peer-review scientific journals before considering the inclusion of a disorder, and justifiably so. Gille de La Tourette first described his syndrome in 1885. It was not until 1980, 95 years later, that the disorder found its way into the DSM. It is important to note that at that point, Tourette's *Syndrome* became Tourette's *Disorder*. Asperger first described his syndrome in 1957. It was not until 1994, 37 years later, that it was accepted into DSM-IV and Asperger's *Syndrome* became Asperger's *Disorder*.

DSM-IV states specifically that all disorders contained in the volume are "syndromes or patterns" (p. xxi), and they would not be there if they were not syndromes (American Psychiatric Association, 1994). Once accepted, the name *syndrome* is changed to *disorder*. However, this is not automatically the pattern for nonpsychiatric disorders. Often the term *syndrome* becomes locked into the name and becomes so well known that changing the word *syndrome* to *disorder* would seem awkward. For example, Down's syndrome, although well recognized, has never become Down's disorder. Similarly, AIDS (Autoimmune Deficiency Syndrome) is a well-recognized disease but still retains the syndrome term.

One of the most important (if not *the* most important) determinants as to whether a newly described disorder will be accepted into the DSM is the quantity and quality of research articles on the clinical entity, especially articles that have been published in peer-review journals. The committees are particularly interested in interrater reliability studies that will validate the relative "purity" of the disease entity being described. PAS lends itself well to such studies; PA does not. One of the first steps one must take when setting up a scientific study is to define and circumscribe the group(s) being studied. PAS lends itself well to such circumscription. PA is so diffuse and all-encompassing that no competent researcher would consider such a group to be a viable object of study. Whether one is going to study etiology, symptomatic manifestations, pathogenesis, treatment modalities, treatment efficacy, or conduct follow-up studies, one is more likely to obtain meaningful results if one starts with a discrete group (such as PAS) than if one starts with an amorphous group (such as PA). One of the major criticisms directed against many research projects is that the authors' study group was not "pure" enough and/or well-selected enough to warrant the professed conclusions. Studies of PAS children are far less likely to justify this criticism than studies of PA children.

Whereas the PAS may ultimately be recognized in DSM-V, it is extremely unlikely that DSM committees will consider an entity referred to as *parental alienation*. It is too vague a term and covers such a wide variety of clinical phenomena that they could not justifiably be clumped together to warrant inclusion in DSM as a *specific* disorder. Because listing in the DSM ensures admissibility in courts of law, those who use the term PA instead of PAS are lessening the likelihood that PAS will be listed in DSM-V. The result will be that many PAS families will be deprived of the proper recognition they deserve in courts of law, which often depend heavily on the DSM.

Recognition of the PAS in Courts of Law

Some who hesitate to use the term PAS claim that it has not been accepted in courts of

law. This is not so. Although there are certainly judges who have not recognized the PAS, there is no question that courts of law with increasing rapidity are recognizing the disorder. My website (www.rgardner.com/refs) currently cites 66 cases in which the PAS has been recognized. By the time this article is published, the number of citations will certainly be greater. Furthermore, I am certain that there are other citations that have not been brought to my attention.

It is important to note that on January 30, 2001, after a two-day hearing devoted to whether the PAS satisfied Frye Test criteria for admissibility in a court of law, a Tampa, Florida court ruled that the PAS had gained enough acceptance in the scientific community to be admissible in a court of law (Kilgore v. Boyd, 2001). This ruling was subsequently affirmed by the District Court of Appeals (February 6, 2001). In the course of my testimony, I brought to the court's attention the more than 100 peer-reviewed articles (there are 133 at the time of this writing) by approximately 150 other authors and over 40 court rulings (there are 66 at the time of this writing) in which the PAS had been recognized. These lists of the PAS peer-reviewed articles and legal citations are frequently updated on my website (www.rgardner.com). I am certain that these publications played an important role in the judge's decision. This case will clearly serve as a precedent and facilitate the admission of the PAS in other cases—not only in Florida, but elsewhere.

Whereas there are some courts of law that have not recognized PAS, there are far fewer courts that have not recognized PA. This is one of the important arguments given by those who prefer the term PA. They do not risk an opposing attorney claiming that PA does not exist or that courts of law have not recognized it. There are some evaluators who recognize that children are indeed suffering with a PAS, but studiously avoid using the term in their reports and courtroom, because they fear that their testimony will not be admissible. Accordingly, they use PA, which is much safer, because they are protected from the criticisms so commonly directed at those who use PAS. Later in this article I will detail the reasons why I consider this position injudicious.

Many of those who espouse PA claim not to be concerned with the fact that their more general construct will be less useful in courts of law. Their primary interest, they profess, is the expansion of knowledge about children's alienation from parents. Considering the fact that the PAS is primarily (if not exclusively) a product of the adversary system, and considering the fact that PAS symptoms are directly proportionate to the intensity of the parental litigation, and considering the fact that the court that has more power than the therapist to alleviate and even cure the disorder, PA proponents who claim no concern for the long-term legal implications of their position are injudicious and, I suspect, their claims of unconcern are specious.

Sources of the Controversy Over the Parental Alienation Syndrome

There are some who claim that because there is such controversy swirling around the PAS, there must be something specious about the existence of the disorder. Those who discount the PAS entirely because it is "controversial" sidestep the real issues, namely, what specifically has engendered the controversy, and, more importantly, is the PAS formulation reasonable and valid? The fact that something is controversial does not invalidate it. But why do we have such controversy over the PAS? With regard to whether PAS exists, we generally do not see such controversy regarding most other clinical entities in psychiatry. Examiners may have different opinions regarding the etiology and treatment of a particular psychiatric disorder, but there is usually some consensus about its existence. And this should especially be the case for a relatively "pure" disorder such as the PAS, a disorder that is easily diagnosable because of the similarity of the children's symptoms when one compares one family with another. Why,

then, should there be such controversy over whether or not PAS exists?

The PAS and the Adversary System

The PAS is very much a product of the adversary system (Gardner, 1985a, 1986, 1987a, 1987b, 1989, 1992, 1998). Furthermore, a court of law is generally the place where clients attempt to resolve the PAS. Most newly developed scientific principles inevitably become controversial when they are dealt with in the courtroom. It behooves the attorneys — when working within the *adversary system* — to take an adversarial stand and create controversy where it may not exist. In that setting, it behooves one side to take just the opposite position from the other if one is to prevail. Furthermore, it behooves each attorney to attempt to discredit the experts of the opposing counsel. A good example of this phenomenon is the way in which DNA testing was dealt with in the OJ Simpson trial. DNA testing is one of the most scientifically valid procedures for identifying perpetrators. Yet the jury saw fit to question the validity of such evidence, and DNA became, for that trial, controversial. I strongly suspect that those jury members who concluded that DNA evidence was not scientifically valid for OJ Simpson would have vehemently fought for its admissibility if they themselves were being tried for a crime, which they did not commit. I am certain, as well, that any man in that jury who found himself falsely accused of paternity would be quite eager to accept DNA proof of his innocence.

The Denial of the PAS is the Primary Defense of the Alienator

A parent accused of inducing a PAS in a child is likely to engage the services of a lawyer who may invoke the argument that there is no such thing as a PAS. The reasoning goes like this: "If there is no such thing as the PAS, then there is no programmer, and therefore my client cannot be accused of brainwashing the children." This is an extremely important point, and I cannot emphasize it strongly enough. It is a central element in the controversy over the PAS, a controversy that has been played out in courtrooms not only in the United States but in various other countries as well. And if the allegedly dubious lawyer can demonstrate that the PAS is not listed in DSM-IV, then the position is considered "proven" (I say "allegedly" because the lawyer may well recognize the PAS but is only serving his client by his deceitfulness). The only thing this proves is that in 1994 DSM-IV did not list the PAS. The lawyers hope, however, that the judge will be taken in by this specious argument and will then conclude that if there is no PAS, there is no programming, and so the client is thereby exonerated. Substituting the term *PA* circumvents this problem. No alienator is identified, the sources are vaguer, and the causes could lie with the mother, the father, or both. The drawback here is that the evaluator may not provide the court with proper information about the cause of the children's alienation. It lessens the likelihood, then, that the court will have the proper data with which to make its recommendations.

Which Term to Use in the Courtroom: PA or PAS?

Many examiners, then, even those who recognize the existence of the PAS, may consciously and deliberately choose to use the term *parental alienation* in the courtroom. Their argument may go along these lines: "I fully recognize that there is such a disease as the PAS. I have seen many such cases and it is a widespread phenomenon. However, if I mention PAS in my report, I expose myself to criticism in the courtroom such as, 'It doesn't exist,' 'It's not in DSM-IV' etc. Therefore, I just use PA, and no one denies that." I can recognize the attractiveness of this argument, but I have serious reservations about this way of dealing with the controversy—especially in a court of law.

Using PA is basically a terrible disservice to the PAS family because the cause of the

children's alienation is not properly identified. It is also a compromise in one's obligation to the court, which is to provide accurate and useful information so that the court will be in the best position to make a proper ruling. Using PA is an abrogation of this responsibility; using PAS is in the service of fulfilling this obligation.

Furthermore, evaluators who use PA instead of PAS are losing sight of the fact that they are impeding the general acceptance of the term in the courtroom. This is a disservice to the legal system, because it deprives the legal network of the more specific PAS diagnosis that could be more helpful to courts for dealing with such families. Moreover, using the PA term is shortsighted because it lessens the likelihood that some future edition of DSM will recognize the subtype of PA that we call PAS. This not only has diagnostic implications, but even more importantly, therapeutic implications. The diagnoses included in the DSM serve as a foundation for treatment. The symptoms listed therein serve as guidelines for therapeutic interventions and goals. Insurance companies (who are always quick to look for reasons to deny coverage) strictly refrain from providing coverage for any disorder not listed in the DSM. Accordingly, PAS families cannot expect to be covered for treatment. I describe below additional diagnoses that are applicable to the PAS, diagnoses that justify requests for insurance coverage. Examiners in both the mental health and legal professions who genuinely recognize the PAS, but who refrain from using the term until it appears in DSM, are lessening the likelihood that it will ultimately be included, because widespread utilization is one of the criteria that DSM committees consider. Such restraint, therefore, is an abrogation of their responsibility to contribute to the enhancement of knowledge in their professions.

There is, however, a compromise. I use PAS in *all* those reports in which I consider the diagnosis justified. I also use the PAS term throughout my testimony. However, I *sometimes* make comments along these lines, both in my reports and in my testimony:

Although I have used the term PAS, the important questions for the court are: Are these children alienated? What is the cause of the alienation? and What can we then do about it? So if one wants to just use the term PA, one has learned something. But we haven't really learned very much, because everyone involved in this case knows well that the children have been alienated. The question is what is the *cause* of the children's alienation? In this case the alienation is caused by the mother's (father's) programming and something must be done about protecting the children from the programming. That is the central issue for this court in this case, and it is more important than whether one is going to call the disorder PA or PAS, even though I strongly prefer the PAS term for the reasons already given.

In addition, if the court does not wish to recognize the PAS diagnosis there are other DSM-IV diagnoses that are very much applicable in this case. For the alienating father (mother) the following diagnoses are warranted: (the examiner can select from the list provided in the next section of this article). For the PAS child the following DSM-IV diagnoses are warranted: (the examiner can select from the list provided in the next section of this article). With regard to the alienated parent, the mother (father), no DSM-IV diagnosis is warranted. (However, a DSM-IV diagnosis may be warranted, but generally it is not related to the PAS as the symptoms have not played a role in contributing to the disorder).

I wish to emphasize that I do not routinely include this compromise, because whenever I do so, I recognize that I am providing support for those who are injudiciously eschewing the term and compromising thereby their professional obligations to their clients and the court.

Warshak (1999, 2001), has also addressed the PA vs. PAS controversy. He emphasizes the point that espousers of both PA and PAS agree that in the severe cases the only hope for the victimized children is significant restriction of the programmer's access to the children and, in many cases, custodial transfer—sometimes via a transitional site. Warshak concludes that the arguments for the utilization for PAS outweigh the arguments for the utilization of PA, although he has more sympathy for the PA position than do I. Elsewhere, I have also addressed myself to this issue (Gardner, 2002).

DSM-IV Diagnoses Related to the Parental Alienation Syndrome

Examiners writing reports for and testifying in courts of law can generally find diagnoses in DSM-IV that are immune to the argument, "It doesn't exist because it's not in DSM-IV." These diagnoses are not identical to the PAS, but they have common elements that can justify their utilization. None of them, however, are identical to the PAS and cannot be used as substitutes for it. I present here those that are most applicable and potentially useful in courts of law.

Diagnoses Applicable to Both Alienating Parents and PAS Children

297.3 Shared Psychotic Disorder

- A. *A delusion develops in an individual in the context of a close relationship with another person(s) who has an already-established delusion.*
- B. *The delusion is similar in content to that of the person who already has the established delusion.*

This DSM-IV diagnosis is warranted in some of the severe PAS cases in which the programmer is paranoid, and the child's campaign of denigration incorporates the same paranoid ideation. In a sense, most of the moderate, and even some of the mild cases of PAS, are examples of the folie à deux phenomenon. However, one cannot justifiably consider the mild and moderate cases of PAS to warrant the label psychotic with the implication of complete break with reality. In severe cases we do see bona fide delusions of persecution that can justifiably be considered paranoid. Most often, the delusional system is circumscribed to the alienated parent. It is important to note that this single diagnosis can be applied to both the alienator and the alienated child.

V61.20 Parent-Child Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between parent and child (e.g., impaired communication, overprotection, inadequate discipline) that is associated with clinically significant impairment in individual or family functioning or the development of clinically significant symptoms in parent or child.

This diagnosis generally applies to a dyad. Obviously, there are a wide variety of parent-child relational problems that have nothing to do with PAS. In fact, it is reasonable to state that parent-child relational problems probably began with the first families that existed. This diagnosis is an excellent example of the aforementioned principle that none of the DSM-IV diagnoses described here can be reasonably substituted for the PAS. Rather, they are best viewed as disorders that have some symptoms in common with the PAS and may therefore justify being listed as additional diagnoses.

In the PAS situation there is a pathological dyad between the alienating parent and the

child and another pathological dyad between the alienated parent and the child. The pathological dyad between the alienated parent and the child is one in which the child is being programmed into a campaign of denigration against the previously loving parent. The child is being programmed to exhibit any and all of the primary symptomatic manifestations of the PAS. With regard to the relationship between the child and the alienated parent, the child exhibits inordinate hostility, denigration, and fear of the target parent to the point where that parent is viewed as noxious and loathsome. Examiners using this criterion do well to emphasize that two separate parent-child relational problems are manifested.

Diagnoses Applicable to Alienating Parents

297.71 Delusional Disorder

- A. *Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.*

Of the various subtypes of delusional disorder, the one that is most applicable to the PAS:

Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way

This diagnosis is generally applicable to the PAS indoctrinator who may initially recognize that the complaints about the behavior of the alienated parent are conscious and deliberate fabrications. However, over time, the fabrications may become delusions, actually believed by the programming parent. And the same process may ultimately be applicable to the child. Specifically, at first the child may recognize that the professions of hatred are feigned and serve to ingratiate the child to the programmer. However, over time the child may come to actually believe what were originally conscious and deliberate fabrications. When that point is reached the delusional disorder diagnosis is applicable to the child. Generally, this diagnosis is applicable to relentless programmers who are obsessed with their hatred of the victim parent, by which time the child will have probably entered the severe level of PAS. It is to be noted that when the PAS is present, most often one observes a circumscribed delusional system, confined almost exclusively to the alienated parent. This diagnosis may also be applicable to the PAS child, especially the child who is in the severe category.

301.0 Paranoid Personality Disorder

- A. *A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:*

1. *suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her*
2. *is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates*
3. *is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her*
4. *reads hidden demeaning or threatening meanings into benign remarks or events*

5. *persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights*
6. *perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack*
7. *has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner*

PAS programmers who warrant this diagnosis would often satisfy these criteria before the marital separation. A detailed history from the victim parent as well as collaterals may be important because the programming parent is not likely to directly reveal such symptoms. They may, however, reveal them in the course of the evaluation, because they are such deep-seated traits, and are so deeply embedded in their personality structure, that they cannot be hidden. Most people involved in protracted child-custody litigation become "a little paranoid," and this is often revealed by elevations on the paranoid scale of the MMPI. After all, there are indeed people who are speaking behind the patient's back, are plotting against them, and are developing schemes and strategies with opposing lawyers. This reality results in an elevation of the paranoid scale in people who would not have manifested such elevations prior to the onset of the litigation. We see here how adversarial proceedings intensify psychopathology in general (Gardner, 1986), and in this case, paranoid psychopathology especially. The PAS child is less likely to warrant this diagnosis. When the severe level is reached PAS children may warrant the aforementioned *Shared Psychotic Disorder* diagnosis. On occasion, the diagnosis *Schizophrenia, Paranoid Type* (295.30) is warranted for the programming parent, but such patients generally exhibited other manifestations of schizophrenia, especially prior to the separation. It goes beyond the purposes of this paper to detail the marital symptoms of schizophrenia which should be investigated if the examiner has reason to believe that this diagnosis may be applicable.

It is important for the examiner to appreciate that there is a continuum from delusional disorder, to paranoid personality disorder, to paranoid schizophrenia. Furthermore, in the course of protracted litigation, a patient may move along the track from the milder to a more severe disorder on this continuum.

301.83 Borderline Personality Disorder (BPD)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. *frantic efforts to avoid real or imagined abandonment.*
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. *a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation*
3. *identity disturbance: markedly and persistently unstable self-image or sense of self*
4. *impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).*
Note Do not include suicidal or self-mutilating behavior covered in

Criterion 5.

5. *recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior*
6. *affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)*
7. *chronic feelings of emptiness*
8. *inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)*
9. *transient, stress-related paranoid ideation or severe dissociative symptoms*

Some alienators may exhibit some of these symptoms prior to the separation. However, as a result of the stresses of the separation, the symptoms may progress to the point where the diagnosis is applicable. Criterion (1) is likely to be exhibited soon after the separation because the marital dissolution is generally associated with real feelings of abandonment. Criterion (2) is often seen when there is a dramatic shift from idealization of the spouse to extreme devaluation. The campaign of denigration is the best example of this manifestation of BPD.

Criterion (4) may manifest itself by excessive spending, especially when such spending causes significant stress and grief to the alienated parent. Following the separation, alienating parents may satisfy Criterion (6) with affect instability, irritability, and intense episodic dysphoria. Although such reactions are common among most people involved in a divorce, especially when litigating the divorce, patients with BPD exhibit these symptoms to an even greater degree. Chronic feelings of emptiness (Criterion [7]) go beyond those that are generally felt by people following a separation. Criterion (8) is extremely common among PAS programmers. The tirades of anger against the alienated parent serve as a model for the child and contribute to the development of the campaign of denigration. The stress-related paranoia, an intensification of the usual suspiciousness exhibited by people involved in litigation, may reach the point that Criterion (9) is satisfied.

The examiner should note which of the symptoms are present and comment: "Five criteria need to be satisfied for the BPD diagnosis. Ms. X satisfies four. Although she does not qualify for the diagnosis at this point, she is at high risk for its development. Furthermore, when one lists diagnoses at the end of the report one might note the DSM-IV diagnosis and add in parenthesis "incipient."

301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. *has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)*
2. *is preoccupied with fantasies of unlimited success, power, brilliance,*

beauty, or ideal love

3. *believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)*
4. *requires excessive admiration*
5. *has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations*
6. *is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends*
7. *lacks empathy: is unwilling to recognize or identify with the feelings and needs of others*
8. *is often envious of others or believes that others are envious of him or her*
9. *shows arrogant, haughty behaviors or attitudes*

My experience has been that most PAS indoctrinators do not satisfy enough criteria (five) to warrant this diagnosis. However, many do exhibit three or four of them, which is worthy of the examiner's attention and should be noted in the report.

Criterion (5) is especially common in PAS indoctrinators. They act as if court orders have absolutely nothing to do with them, even though their names may be specifically spelled out in the ruling. Unfortunately, they often violate these orders with impunity because courts are typically lax with regard to implementing punitive measures for PAS contemnors. As mentioned in other publications of mine (Gardner, 1998; 2001), the failure of courts to take action against PAS programmers is one of the most common reasons why the symptoms become entrenched in the children.

Criterion (6) is often frequently satisfied by the programmer's ongoing attempts to extract ever more money from the victim parent, but feels little need to allow access to the children. There is no sense of shame or guilt over this common form of exploitation. The programmer's lack of empathy and sympathy for the victim parent is quite common and easily satisfies Criterion (7). The PAS, by definition, is a disorder in which a programmer tries to destroy the bond between the children and a good, loving parent. In order to accomplish the goal, the alienator must have a serious deficiency in the ability to empathize with the target parent. Criterion (9) is often seen in that PAS indoctrinators are often haughty and arrogant and this symptom goes along with their sense of entitlement. Again, if warranted, the diagnosis can be listed as "incipient."

DSM-IV Diagnoses Applicable to PAS Children

312.8 Conduct Disorder

- A. *A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:*

This diagnosis is often applicable to the PAS child, especially in situations when the conduct disturbances are the most salient manifestation. Under such circumstances, an examiner who is not familiar with the PAS may erroneously conclude that this is the only diagnosis. Such a conclusion necessitates selective inattention to the programming process, which is the hallmark of the PAS. Once again, we see here how a diagnosis, although in DSM-IV, cannot be used as a substitute for the PAS, but may be used as an additional diagnosis. I will not list here all 15 of the DSM-IV criteria, but only those that are most applicable to the PAS:

Aggression to people and animals

1. *often bullies, threatens, or intimidates others*
2. *often initiates physical fights*
3. *has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)*
4. *has been physically cruel to animals*
5. *has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)*

Destruction of property

6. *has deliberately engaged in fire setting with the intention of causing serious damage*
7. *has deliberately destroyed others' property (other than by fire setting)*

Deceitfulness or theft

8. *often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)*
9. *has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)*

Serious violations of rules

10. *has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)*

As can be seen, most of the 15 criteria for the conduct disorder diagnosis can be satisfied by PAS children, especially those in the severe category. The target parent is very much scapegoated and victimized by PAS children. In severe cases they are screamed at, intimidated, and sometimes physically assaulted with objects such as bats, bottles, and knives. The child may perpetrate acts of sabotage in the home of the victim parent. Destruction of property in that person's home is common and, on rare occasion, even fire setting. Deceitfulness is common, especially fabrications facilitated and supported by the alienator. Stealing things, such as legal documents and important records, and bringing them to the home of the alienator is common. Running away from the home of the target parent and returning to the home of the alienator is common, especially in moderate and severe cases.

309.21 Separation Anxiety Disorder

- A. *Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:*

I reproduce here those of the eight criteria that are applicable to the PAS:

- 1) *recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated*
- 4) *persistent reluctance or refusal to go to school or elsewhere because of fear of separation*
- 8) *repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated*

It is important for the reader to appreciate that the original diagnosis for separation anxiety disorder was school phobia. The term separation anxiety disorder is a relatively recent development emerging from the recognition that the child's fear was less that of the school per se and much more related to the fear of separation from a parent, commonly an overprotective mother (Gardner, 1985b). DSM-IV recognizes this and doesn't necessarily require the school to be the object of fear, but rather separation from the home, especially from someone with whom the child is pathologically attached.

It is important to note that the PAS child's hatred of the victim parent has less to do with actual dislike of that parent and has much more to do with fear that if affection is displayed toward the target parent, the alienating parent will be angry at and rejecting of the child. At the prospect of going with the victim parent, the child may exhibit a wide variety of psychosomatic symptoms, all manifestations of the tension associated with the visit. The distress may be especially apparent when the alienating parent is at the site of the transfer. The child recognizes that expression of willingness or happiness to go off with the alienated parent might result in rejection by the alienator. The separation anxiety disorder diagnosis is most often applicable to the mild and moderate cases of PAS. In the severe cases, the anxiety element is less operative than the anger element.

When applying these criteria to the PAS child, one does well to substitute the PAS indoctrinating parent for the parent with whom the child is pathologically attached. At the same time one should substitute the alienated parent for the school or other place outside the child's home. When one does this, one can see how most of the aforementioned criteria apply. When the child with a separation anxiety disorder is fearful of leaving the home to go to many destinations, the school is the destination the child most fears. It is there that the child feels imprisoned. In contrast, PAS children generally fear only the target parent and are not afraid to leave the programming parent and go elsewhere, such as to the homes of friends and relatives. In short, the PAS child's fear is focused on the alienated parent. In contrast, the child with a separation anxiety disorder has fears that focus on school but which have spread to many other situations and destinations.

300.15 Dissociative Disorder
Not Otherwise Specified

This category is included for disorders in which the predominant feature is a dissociative symptom (i.e., a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does

not meet the criteria for any specific Dissociative Disorder. Examples include:

3. *States of dissociation that occur in individuals who have been subjected to periods of prolonged and coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).*

Of the four categories of dissociative disorder (NOS), only Category 3 is applicable to the PAS. This criterion was designed for people who have been subjected to cult indoctrinations or for military prisoners subjected to brainwashing designed to convert their loyalty from their homeland to the enemy that has imprisoned them. It is very applicable to PAS children, especially those in the severe category. Such children have been programmed to convert their loyalty from a loving parent to the brainwashing parent exclusively. Cult victims and those subjected to prisoner indoctrinations often appear to be in a trance-like state in which they profess their indoctrinations in litany-like fashion. PAS children as well (especially those in the severe category) are often like robots or automatons in the way in which they profess the campaign of denigration in litany-like fashion. They seem to be in an altered state of consciousness when doing so.

Adjustment Disorders

The following subtypes of adjustment disorders are sometimes applicable to PAS children:

309.0 With Depressed Mood.

309.24 With Anxiety.

309.28 With Mixed Anxiety and Depressed Mood.

309.3 With Disturbance of Conduct.

309.4 With Mixed Disturbance of Emotions and Conduct

Each of these types of adjustment disorders may be applicable to the PAS child. The child is indeed adjusting to a situation in which one parent is trying to convince the youngster that a previously loving, dedicated, and loyal parent has really been noxious, loathsome, and dangerous. The programmed data does not seem to coincide with what the child has experienced. This produces confusion. The child fears that any expression of affection for the target parent will result in rejection by the alienator. Under such circumstances, the child may respond with anxiety, depression, and disturbances of conduct.

313.9 Disorder of Infancy, Childhood or Adolescence Not Otherwise Specified

This category is a residual category for disorders with onset in infancy, childhood, or adolescence that do not meet criteria for any specific order in the Classification.

This would be a "last resort" diagnosis for the PAS child, the child who, although suffering with a PAS, does not have symptoms that warrant other DSM-IV childhood diagnoses. However, if one still feels the need to use a DSM-IV diagnosis, especially if the report will be compromised without one, then this last-resort diagnosis can justifiably be utilized. However, it is so vague that it says absolutely nothing other than that the person who is suffering with this disorder is a child. I do not recommend its utilization because of its weakness and because it provides practically no new information to the