

APSAC Responds to Inclusion of PAS/PAD Information in *Diagnostic and Statistical Manual of Mental Disorders*

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APSAC's response to the [DSM-V/Bernet] proposal that parental alienation syndrome (PAS) or parental alienation disorder (PAD) be included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V), to be published in 2013.

The American Professional Society on the Abuse of Children (APSAC) is "the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence" (APSAC, 2010). The mission of this organization is to foster the best professional response to child maltreatment and violence. Consistent with its mission, APSAC raises concerns about the inclusion of parental alienation syndrome (PAS), parental alienation disorder (PAD), and/or parental alienation in the DSM-V. In partial support of these concerns, we append a letter, signed by the leading researchers on parental alienation—Janet Johnston, PhD, and Joan Kelly, PhD—and cosigned by 17 leading researchers, teachers, and clinicians with extensive experience in the domain of familial dissolution and child response to family break-up. [Editor's note: The referenced letter and the original proposal can be requested from APSAC.]

The major focus of APSAC's concerns is on the proposed DSM-V criteria for PAD and whether there is research to support these criteria. Although there are a number of articles describing parental alienation as a phenomenon in divorce (Warshak, 2008), the empirical data supporting a disorder are quite weak (e.g., Bruch, 2002; Faller, 1998; Kelly & Johnston, 2001), especially with regard to the criteria proposed by William Bernet, MD (Bernet, 2008, 2009; Bernet, von Boch-Galhau, Baker, & Morrison, 2010). According to Dr. Bernet and his colleagues, the criteria for PAD are as follows:

Proposed Criteria for Parental Alienation Disorder

A. The child—usually the parents are engaged in a hostile divorce—allies himself or herself strongly with one parent and rejects a relationship with the other, alienated parent without legitimate justification. The child resists or refuses visitation or parenting time with the alienated parent.

Comment: The divorce rate is very high in the United States. Almost half of U.S. marriages end in divorce (U.S. Library of Medicine, 2009); approximately four million couples obtain divorces annually (CDC, 2002, 2009). More than half of divorces involve children under the age of 18, although couples with children are slightly less likely to divorce than childless couples (CDC, 2009).

Anger at one or both parents is a normative emotional reaction to divorce by children (Mayo Clinic staff, 2009). This anger and alienation from one or both parents can have a wide range of etiologies and often involves a complex mix of causes (e.g., Corwin, Berliner, Goodman, Goodwin, & White, 1987; Garrity & Baris, 1994; Kelly & Johnston, 2001; Jaffe, Johnston, Crooks, & Bala, 2008; Johnston & Roseby, 1997; Mason, 1999).

A fundamental vulnerability of PAD is that it assumes that the professional evaluating the "alienated child" is omniscient, that is, the professional knows all the sources of the child's rejection of a parent. Most important from the perspective of APSAC, PAD assumes the professional knows with sufficient certainty that the child has NOT been maltreated or otherwise traumatized by the parent he or she is trying to avoid by refusing to visit. Research has consistently demonstrated that a substantial proportion of children fail to disclose maltreatment (e.g., London, Bruck, Ceci, & Schuman, 2005; Lyon, 2007) and/or delay disclosure (e.g., Lamb, Herskowitz, Orbach, & Esplin, 2008; Lyon, 2007; Sas & Cunningham, 1995) and may subsequently recant their earlier disclosures (e.g., Malloy, Lyon, & Quas, 2007). Indeed, PAD relies heavily on subjective judgment of the professional making the diagnosis that the child's rejection is "without legitimate justification."

B. The child manifests the following behaviors:

- 1. a persistent rejection or denigration of a parent that reaches the level of a campaign**
- 2. weak, frivolous, and absurd rationalizations for the child's persistent criticism of the rejected parent.**

Comment: Consistent with observations regarding Criterion A, Criterion B assumes omniscience of the professional and relies on the professional's subjective interpretation of the child's behaviors and statements. Moreover, the terms used to describe the child's behaviors are not defined. For example, what behavioral manifestations must a child evidence for the child's response to be termed a "campaign"? What behaviors are associated with "weak, frivolous, and absurd rationalizations"? Thus, how will mental health experts determine that the child's behaviors constitute a campaign and that they are weak, frivolous, and absurd?

C. The child manifests two of the following six attitudes and behaviors:

- 1. lack of ambivalence**
- 2. independent-thinker phenomenon**
- 3. reflexive support of one parent against the other**
- 4. absence of guilt over exploitation of the rejected parent**
- 5. presence of borrowed scenarios**
- 6. spread of the animosity to the extended family of the rejected parent.**

Comment: Again, Bernet and colleagues do not define terms, and they propose specific "attitudes and behaviors" that require undue reliance on the professional's subjective judgment. Especially lacking in clarity are the following attitudes and behaviors under Criterion C: (2) independent-thinker phenomenon, and (5) presence of borrowed scenarios. Dr. Gardner included these six indicators in his definition of the parental alienation syndrome 20 years ago (Gardner, 1992, pp. 75–82; see also Gardner, 1998). These attitudes and behaviors appear to be taken directly from Gardner's original work without any critical examination. They are not described in sufficient detail so other mental health professionals

can understand exactly what these attitudes and behaviors entail. It is surprising that in the intervening 20 years no better definitions and no research have attempted to measure these characteristics in any systematic way.

D. The duration of the disturbance is at least 2 months.

Comment: The rationale for this duration is not specified. Most childhood disorders in the DSM IV require a duration of 4 weeks or a year. Adult disorders are diagnosable after a duration of 6 months.

E. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

Comment: Children whose parents are involved in a divorce may have clinically significant disturbance for a spectrum of reasons, for example, because their parents' relationship was violent or conflictual before marital dissolution, because their parents are divorcing, because the divorce involves parental conflict, or because the children have been harmed or traumatized. The domains of disturbance, therefore, do not illuminate the etiology.

F. The child's refusal to have visitation with the rejected parent is without legitimate justification. That is, parental alienation disorder is not diagnosed if the rejected parent maltreated the child.



Comment: The first parts of this Criterion, “refusal of visitation” and “without legitimate justification,” are redundant with Criterion A and B(2). And yet again, there is a reliance on the omniscience of the mental health expert, that he or she is certain there has been no maltreatment or trauma.

Concluding Comment

Although PAD is described as a relational disorder, the diagnostic criteria are all found in the child. Thus, the child, not the adult, is assumed to have PAD. The absence of reference to any adult behavior has the result of blaming the child, who may have experienced maltreatment the professional is unaware of. At the very least, the child has experienced parental divorce, which research indicates has lasting traumatic impact (e.g., Wallerstein, 1998).

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