

## Denial of the Parental Alienation Syndrome Also Harms Women

by Dr. Richard A. Gardner

*Denying reality is obviously a maladaptive way of dealing with a situation. In fact, denial is generally considered to be one of the defense mechanisms, mechanisms that are inappropriate, maladaptive, and pathological. In the field of medicine to deny the existence of a disease seriously compromises the physician's ability to help patients. If a physician does not believe that a particular disease exists, then it will not be given consideration when making a differential diagnosis, and the patient may then go untreated. This is in line with the ancient medical principle that proper diagnosis must precede proper treatment. Or, if for some external reason the physician recognizes the disorder, but feels obligated to use another name, other problems arise, e.g., impaired communication with others regarding exactly what is going on with the patient, and hence improper treatment. This is what is occurring at this point with the parental alienation syndrome, a disorder whose existence has compelling verification.*

*In this article I discuss the reasons for denial of the PAS and the ways in which such denial harms families. Particular emphasis will be given to the ways in which this denial harms women, although I will certainly comment on the ways in which the denial harms their husbands and children. In the past, denial of the PAS has caused men much grief. Such denial is now causing women similar grief.*

Since the 1970s, we have witnessed a burgeoning of child-custody disputes unparalleled in history. This increase has primarily been the result of two recent developments in the realm of child-custody litigation, namely, the replacement of the tender-years presumption with the best-interests-of-the-child presumption and the increasing popularity of the joint-custodial concept. Under the tender-years presumption, the assumption was made that mothers, by virtue of the fact that they are female, are intrinsically superior to men as child rearers. Accordingly, the father had to provide the court with compelling evidence of serious maternal deficiencies before the court would even consider assigning primary custodial status to the father. Under its replacement, the best-interests-of-the-child presumption, the courts were instructed to ignore gender when adjudicating child-custody disputes and evaluate only parenting capacity, especially factors that related to the best interests of the child. This change resulted in a burgeoning of custody litigation as fathers found themselves with a greater opportunity to gain primary custodial status. Soon thereafter the joint-custodial concept came into vogue, eroding even further the time that custodial mothers were given with their children. Again, this change also brought about an increase and intensification of child-custody litigation.

### 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 applicable. Accordingly, in 1985, I introduced the term parental alienation syndrome to cover the combination of these two contributing factors (Gardner, 1985, 1987a). In accordance with this use of the term I suggest this definition of the parental alienation syndrome:

*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 a good, loving 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 diagnosis is not applicable.*

The alienating parent's primary purpose for indoctrinating into the children a campaign of denigration against the target parent is to gain leverage in the court of law. The child's alienation has less to do with bona fide animosity or even hatred of the alienated parent, but more to do with the fear that if such acrimony is not exhibited, the alienating parent will reject the child.

These are the primary symptomatic manifestations of the parental alienation syndrome:

1. A campaign of denigration
2. Weak, absurd, or frivolous rationalizations for the deprecation
3. Lack of ambivalence
4. The "independent-thinker" phenomenon

**Please  
take  
our  
survey**

go 

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

There are three types of parental alienation syndrome: mild, moderate, and severe. It goes beyond the purposes of this article to describe in full detail the differences between these three types. At this point only a brief summary is warranted. In the mild type, the alienation is relatively superficial, the children basically cooperate with visitation, but are intermittently critical and disgruntled with the victimized parent. In the moderate type, the alienation is more formidable, the children are more disruptive and disrespectful, and the campaign of denigration may be almost continual. In the severe type, visitation may be impossible so hostile are the children, hostile even to the point of being physically violent toward the allegedly hated parent. Other forms of acting-out may be present, acting-out that is designed to inflict ongoing grief upon the parent who is being visited. In some cases the children's hostility may reach paranoid levels, e.g., they exhibit delusions of persecution and/or fears that they will be murdered. Each type requires a different psychological and legal approach. Further details about the diagnosis and treatment of the parental alienation syndrome have been described elsewhere (Gardner, 1992, 1998, 2001a).

### **Mothers as Alienators**

In the early 1980s, when I first began seeing the PAS, in about 85% to 90% of the cases the mother was the alienating parent and the father the targeted parent. Fathers were certainly trying to program their children to gain leverage in the custody dispute; however, they were less likely to be successful. This related to the fact that the children were generally more closely bonded with their mothers. Recognizing this, I generally recommended the mother to be designated the primary custodial parent, even though she might have been a PAS indoctrinator. It was only in the severe cases (about 10 percent)—when the mother was relentless and/or paranoid and unable to cease and desist from the programming—that I recommended primary custodial status to the father. I was not alone in recognizing this gender disparity, which was confirmed during that period by others. In my experience, the time frame during which mothers were the primary alienators was from the early 1980s (when the disorder first appeared) to the mid-to-late 1990s (when fathers became increasingly active as PAS indoctrinators). The largest study confirming the preponderance of mothers as PAS alienators during the 1980s was that of Clawar and Rivlin (1991).

During this early period, it was quite common for mothers, with the full support of their attorneys, to not only deny that they were PAS programmers, but even went further and denied that the PAS existed. And this denial was especially common in courts of law where their attorneys would argue that there was no such thing as a PAS, and therefore, their clients could not be suffering with a disorder that does not exist. In many cases, neither the mothers nor their attorneys could deny that the children were alienated, but would claim that the alienation was the result of abuse and/or neglect to which the children were subjected by their fathers. Under such circumstances, confusion prevailed and "the waters were muddied," especially in the courtroom. The PAS diagnosis demands the identification of the specific alienator. Other sources of abuse and/or neglect do not produce this particular constellation of symptoms and do not focus so clearly on a specific alienator. In this more confused environment, the mother's diagnosis as a PAS programmer might never come to the attention of the court—especially if the lawyer was able to convince the court that there was no such thing as a parental alienation syndrome.

### **"PAS is Not a Syndrome"**

Often, the mother's lawyer would argue that PAS was not a syndrome, with the implication that it does not exist. 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.

Accordingly, there is a kind of purity that a syndrome has that may not be seen in other diseases. For example, a person suffering with pneumococcal pneumonia may have chest pain, cough, purulent sputum, and fever. However, the individual may still have the disease without all these symptoms manifesting themselves. A syndrome is more "pure" because most (if not all) of the symptoms in the cluster predictably manifest themselves. 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-type facial expression, drooping lips, slanting eyes, short fifth finger, and atypical creases in the palms of the hands. There is a consistency here in that the people who suffer with Down's Syndrome often look very much alike and 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. Typically, children who suffer with PAS will exhibit most (if not all) of the eight symptoms described above. This is almost uniformly the case for the moderate and severe types. 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. Due to this purity the PAS lends itself well to research studies, because the population to be studied can

easily be identified. Furthermore, I believe that this purity will be verified by interrater reliability studies. As is true of other syndromes, there is an 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.

### "PAS Does Not Exist Because It Is Not in DSM-IV"

Commonly, the mother's attorneys would argue that PAS does not exist because it is not in DSM-IV (1994). The DSM committees justifiably are quite conservative with regard to the inclusion of newly described clinical phenomena and require many years of research and publications before considering inclusion of a disorder. This is as it should be. Lawyers involved in child-custody disputes see it repeatedly. Mental health professionals involved in such disputes are continually involved with such families. They may not wish to recognize it. They may refer to PAS by another name (like "parental alienation") (Gardner, 2002a). But that does not preclude its existence. A tree exists as a tree regardless of the reactions of those looking at it. A tree still exists even though some might give it another name. If a dictionary selectively decides to omit the word tree from its compilation of words, that does not mean that the tree does not exist. It only means that the people who wrote that book decided not to include that particular word. Similarly, for someone to look at a tree and say that the tree does not exist does not cause the tree to evaporate. It only indicates that the viewer, for whatever reason, does not wish to see what is right in front of him (her).

DSM-IV was published in 1994. In the early 1990s, when DSM committees were meeting to consider the inclusion of additional disorders, there were too few articles on the PAS in the literature to warrant its submission for consideration. That is no longer the case. It is my understanding that committees will begin to meet for DSM-V in 2003. At this point, DSM-V is scheduled for publication in 2010. Considering the fact that there are now more than 135 articles on the PAS in peer-review journals, it is highly likely that by that time there will be many more. Furthermore, considering the fact that there are now more than 65 rulings in which courts have recognized the PAS, it is probable that there will be even more such rulings by the time the committees meet. These lists are being continually updated and can be found on my website ([www.rgardner.com/refs](http://www.rgardner.com/refs)). At the time the DSM-V committees meet, these lists will be in the proposal to include PAS in DSM-V. Elsewhere (Gardner, 2002b) I have discussed the various alternative diagnoses that therapists might use in courts that stringently refuse to accept the PAS diagnosis at this time.

It is important to note that DSM-IV does not frivolously accept every new proposal. Their requirements are quite stringent, 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, and they would not be there if they were not syndromes. Once accepted the name *syndrome* becomes 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* may 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.

### "Believe the Children"

Lawyers for the mothers would often say to the judge, "Your Honor, why don't we really listen to what these children are saying. If you don't feel comfortable putting them on the witness stand, then bring them into your chambers. They will tell you how they feel. Let's respect their opinions." Judges not familiar with the PAS might be taken in by these children, and actually believe that they were subjected to the terrible indignities that they described. As far back as 1987 I wrote an article advising judges about this problem and providing them with guidelines for interviewing these children (Gardner, 1987b). Although there are certainly judges who are now more knowledgeable about the PAS than in the late 1980s, judges still play an important role in the etiology and promulgation of the PAS, especially with regard to their failure to impose reasonable sanctions on PAS indoctrinating parents. Elsewhere (Gardner, submitted for publication), I have elaborated on this problem. The believe-the-children philosophy was—and still is—espoused by therapists ignorant of the PAS. Many therapists sanctimoniously profess that they really listen to children (as opposed to the rest of us who presumably do not). They profess that they really respect what children want (with the implication that the rest of us do not). What they are basically doing is contributing to pathological empowerment, which is a central factor in the development and perpetuation of the PAS (Gardner, 2002c). Again, it is beyond the purposes of this article to describe therapists' role in the development and perpetuation of the PAS. PAS indoctrinators know well that they can rely upon most therapists to empower children's PAS symptomatology, and that they are readily duped into joining the PAS indoctrinator's parade of enablers and supporters. Such therapists are often brought into the courtroom to support the mother and her lawyer's denial of the existence of the PAS and to encourage the court to "really listen" to the children.

### "Those Who Make the PAS Diagnosis Are Sexist"

Because mothers were the primary alienators during this early period, PAS was viewed as being intrinsically biased against women. And I, as the person who first wrote on the phenomenon, was viewed as being biased against women and as being "sexist." The facts are that during this time frame women were the primary alienators. Labeling those who diagnose PAS as sexist is the equivalent of saying that a doctor is biased against women if he claims that more women suffer with breast cancer than men. And the sexist claim has also been brought into courts of law. Fear of being labeled "sexist" has been one factor in many evaluators' eschewing the PAS diagnosis.

## Denial of the PAS Has Caused Permanent Alienation

The denial of PAS has caused many men to suffer formidable psychological suffering. The lawyers of women who have been PAS indoctrinators have convinced courts that PAS does not exist, and therefore the children's animosity against their fathers is justified. The fact that women are increasingly suffering as target parents gives these men little solace, because many of them have lost their children permanently. In my recent follow-up of 99 PAS children, I provide compelling confirmation that the denial of PAS by courts has resulted in permanent estrangement in the vast majority of cases (Gardner, 2001c).

## Fathers as Alienators and Mothers as Target Parents

In the last few years, starting in the late 1990s, there has been a gender shift. Fathers, with increasing frequency, are also indoctrinating PAS into their children (Gardner, 2001b). At this point, my own extensive experiences with PAS families have led me to the conclusion that the ratio is now 50/50, with fathers being as likely as mothers to indoctrinate children into a PAS. And colleagues of mine in various parts of the country are reporting a similar phenomenon.

Why this shift? One probable explanation relates to the fact that fathers are increasingly enjoying expanded visitation time with their children in association with the increasing popularity of shared parenting programs. The more time a programming father has with his children, the more time he has to program them if he is inclined to do so. Another factor operative here probably relates to the fact that with increasing recognition of the PAS, fathers (some of whom have read my books) have learned about the disorder and have decided to use the same PAS indoctrinational maneuvers utilized by women. It is probable that other factors are operative as well in the gender shift, but these are the two best explanations that I have at this point.

With the gender shift of PAS indoctrinators, there has consequently been a gender shift in PAS target parents. Mothers are increasingly finding themselves victims (I use the word without hesitation) of their husbands' PAS indoctrinations of their children. Such mothers know well that PAS exists. They read my books and say, as have the father victims before them, "It's almost as if you've lived in my house. You're describing exactly what has been going on." These mothers find themselves helpless. They cannot get help from therapists who are still mouthing the old mantras, "PAS is just Gardner's theory," "PAS doesn't exist because it's not in DSM-IV," "PAS is not a syndrome." Their lawyers, too, will tell them, "PAS might exist, but the court will not recognize it. I can't use the word syndrome in the courtroom. It's the 'big S' word." Worse yet, many leaders in the Women's Rights movement are reflexively chanting the same incantations, thereby abandoning the women whose cause they profess to espouse. These mantras have become deeply embedded in the brain circuitry of most of the people the alienated women are looking to for help—therapists, lawyers, guardians ad litem, and judges. And these groups cannot even turn to the Women's Rights groups because they have long ago stridently taken the position that PAS does not exist, that PAS is not a syndrome, etc., etc. We see here how those who deny the existence of PAS are adding formidably to the grief of women. Women's past denial and discrediting of PAS has now come back to haunt them. Women are now being injured by their own weapons, or, as the old saying goes, they are being "hoist by their own pitards."

## The Relationship Between PAS and Bona Fide Abuse

In recent years, with increasing frequency, mental health and legal professionals have been seeing cases in which one parent (more often the father) has accused the other parent (more often the mother) of inducing a PAS in the children. In response, the responding parent (usually the mother) accuses the other parent (usually the father) of abusing and neglecting the children. In short, then, the children's alienation against the father is considered by him to be the result of the mother's PAS programming, and the mother considers their alienation to be the result of the father's abuse/neglect. I have no doubt that some abusing/neglectful parents are using the PAS explanation to explain the children's alienation as a cover-up and diversionary maneuver designed to deflect exposure of their abuse/neglect. However, there is no question that some PAS-inducing mothers are using the argument that it is the father's abuse/neglect that is causing the children's campaign of denigration, and thereby denying any programming whatsoever. In short, such programming mothers are basically saying: "He's getting what he deserves, and I'm not programming them." Elsewhere (Gardner, 1998, 1999) I have described criteria for differentiating between PAS and bona fide abuse/neglect.

Of relevance to this article is the common phenomenon in which genuinely abusing husbands use the argument that the children's alienation has nothing to do with their abuse, but is the result of the mother's PAS indoctrinations. Such mothers will invoke the argument that this deceitful maneuver is not going to work, especially because there is no such thing as the PAS. This is a handy argument, and they will easily find legal and mental health professionals who will support them in this denial. Although I am sympathetic with these falsely accused women, their contributions to the denial of the existence of the PAS is not serving well other women who are indeed PAS victims. And this factor has been operative in increasing the grief suffered by women who are indeed PAS target parents. Their PAS indoctrinating husbands are now waving the same "PAS-doesn't-exist" flags that PAS indoctrinating women were waving in the 1980s and early 1990s. Wives who were being falsely accused by their husbands of being PAS indoctrinators would have done much better to agree that PAS does exist, but they themselves are not indoctrinators, that the children's symptoms are not those of PAS children, but symptoms of children who have been genuinely abused.

## The Effects on Children

The denial of PAS in the early period resulted in many children living primarily with their programming mothers, with the result that they became permanently estranged from loving fathers. They were deprived, therefore, of all the benefits that could have come from their father. There is no question that follow-up studies of these children will reveal significant psychopathological residua from these early experiences. One cannot grow up and be a healthy person if, throughout the course of one's childhood, one was taught that a previously loving and

dedicated father was really loathsome and vicious. This inevitably will affect their relationships with other males—dates, boyfriends, teachers, employers, friends, etc. In the more recent phase, with men as increasingly frequent indoctrinators, we will have a similar group of children growing up believing that their previously loving mothers were vile, loathsome, and noxious. Similarly, one cannot become a healthy person believing that the primary maternal figure has been and still is a despicable and loathsome human being. Such a distortion of reality cannot but affect future relationships with other females—dates, employers, friends, etc.

### The Solution

The first step in the treatment of denial is the acceptance of reality. The first step, then, must be the recognition that PAS exists, even if there are thousands of people, both husbands and wives, who claim that it does not. PAS exists, even though there are thousands of lawyers who will claim that it does not. PAS exists even though there are thousands of mental health professionals who claim that it does not. It exists even though there are Courts of Appeal who rule that it does not exist. It exists even if all nine members of the U.S. Supreme Court were to rule that it does not exist. It exists even though it is not in DSM-IV, and it will continue to exist even if the DSM-V committees choose not to include it. The first step, then, must be to recognize and stop denying its existence. Mental health professionals should be free to diagnose the disorder when it is present, and not have to worry about whether the diagnosis will be accepted in a court of law. They should recognize that in the adversarial system there will always be attorneys who will try to discredit whatever they say, because this is what they have learned to do in law school. Mental health professionals should not worry about whether they are in the minority or the majority with regard to the diagnosis. Rather, they should only be concerned with honesty and reality. They should not be concerned with those who may irrationally label them sexist or biased against either men or women if they make a diagnosis of PAS. Whenever some external considerations operate or affect one's diagnostic objectivity, there is bound to be some contamination and bias. Worse, it will inevitably not serve well the patients whom one is evaluating and treating. If this point is reached, it is likely that the frequency of PAS will be reduced because would-be indoctrinators will recognize that they will not have available mental health professionals to help them manipulate the legal system.

### Concluding Comments

Denial of PAS has caused significant psychological suffering to many men, many women, and many children. And its denial has only added to the burden of families in which this disorder has been present. Furthermore, the denial of PAS will lessen the likelihood of ultimate inclusion in DSM-V. And this will have a negative impact on all those who are afflicted with this disorder. The more PAS is recognized, the greater the number of research articles will be written. This will, in turn, enhance the receptivity of the DSM-V committees. The more courts of law that have accepted PAS, the greater the likelihood that the DSM-V committee will recognize the disorder. Mental health professionals, especially, should take this factor into consideration when they eschew the diagnosis.

In closing, I quote from the concluding comments in my follow-up study of 99 PAS children:

When I embarked upon this study, I expected that most of the PAS children would continue to be alienated from the target parent in situations in which the court neither transferred custody to the target parent nor reduced the alienating parent's access to the children. What I did not expect was the high rate of completely destroyed relationships and the enormous grief suffered by the alienated parents. I expected the average follow-up conversation to last five minutes, during which I would get the basic data. It turned out that most conversations lasted between 15 and 30 minutes, because the parents needed me at that point for some kind of ventilation of their painful feelings. I did not expect such a degree of grief. However, on looking back upon the study, I should not have been surprised. I consider losing a child because of PAS to be more painful and psychologically devastating than the death of a child. A child's death is final and there is absolutely no hope for reconciliation. Most bereaved parents ultimately resign themselves to this painful reality. The PAS child is still alive and may even be in the vicinity. Yet, there is little if any contact, when contact is feasible. Therefore, resignation to the loss is much more difficult for the PAS alienated parent than for the parent whose child has died. For some alienated parents the continuous heartache is similar to living death.

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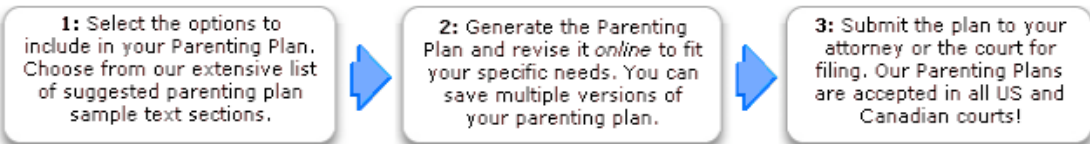
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