Trainee Prize Award Winner

Psychopathology and the conceptualisation of mental disorder: The debate around the inclusion of Parental Alienation in *DSM-5*

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Content and Focus: *This paper will briefly consider the general conceptualisation of mental disorder before focusing on the specific case of Parental Alienation (PA), variously termed a disorder or a syndrome. By virtue of the recent debate surrounding its potential inclusion in the newest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), this is a topical example. A critical analysis of the petition for its inclusion within DSM-5 will both highlight the range of professionals' views, and also consider ethical and practical issues inherent in the conceptualisation of a mental disorder and its classification within the evolving DSM. Following this general and specific conceptualisation of mental disorder, the tensions that diagnosis raises for counselling psychology will be briefly deliberated. The positive aspects of classification and diagnosis will be acknowledged, whilst highlighting the focus on the subjective experience of individual clients.*

Conclusions: *Despite the controversy about the concept, validity and reliability of PA, the evidence suggests that there is more agreement than disagreement among practitioners and professionals in the field. Whilst there is a general consensus that alienation exists within a distinct population who would benefit from intervention, there is no consensus on its inclusion in DSM-5. Irrespective of its inclusion in any nosology, the recent debate has highlighted the need for further research. A greater understanding of the processes, symptoms and behaviours involved in PA will enable the needs of children and families involved in high-conflict separation to be better addressed.*

Keywords: *Parental Alienation; DSM-5; psychopathology; diagnosis; mental disorder.*

MENTAL DISORDERS are not static phenomena. At various times schizophrenia did not exist, bipolar disorder was manic depression and depressive disorder was melancholia treated by blood-letting (Benham, 1915). Homosexuality was a mental disorder subsequently reclassified as sexual orientation disturbance in 1974, before being removed from the *DSM* in 1987. Whilst major revisions in the classification of mental disorder occur infrequently, consideration of psychopathology – conceptualising, debating and clarifying diagnostic criteria and symptomology and investigating and evaluating effective treatments and interventions – is a continuous process. Whilst psychopathology can be defined as 'the study of abnormal states of mind' (Gelder, Cowen & Harrison, 2006, p.2) classification of mental disorder does not fit neatly within tightly defined boundaries; there is no clear cut division between 'normality' and 'psychopathology' (APA, 2000; Maxmen, Ward & Kilgus, 2009).

Over time, a wide range of factors have been used to define different disorders including dysfunction, distress, statistical deviation, disadvantage and aetiology. Current disorders included in the *DSM* are descriptively conceptualised as a 'clinically significant behavioural or psychological syndrome or pattern' (APA, 2000, p.xxxi)

associated with one or more of current distress; impairment in one or more major spheres of functioning; a significantly increased risk of loss of life, pain, disability or loss of freedom. Irrespective of the initial cause, the individual currently exhibits psychological, behavioural or biological dysfunction interpreted within a cultural context (APA, 2000). *DSM-IV* is very much based on a Western conceptualisation of mental health as distinct from physical health, though acknowledging some interplay, whilst Eastern philosophy holds a much more integrated sense of health and well-being.

Classification of a disorder can facilitate a shared understanding of a client amongst clinicians. It can also enable some reasonable predictions about prognosis and inform potential treatments and interventions based upon best evidence. In order for a disorder to be included within a nosology such as the *DSM* there must be wide agreement on diagnostic criteria, especially clinical features, but also aetiology, pathogenesis and response to treatment. An individual or a clinician may be alerted to a possible disorder by the presence of observable signs and reported symptoms. However, signs and symptoms do not always indicate the presence of a classified disorder; a cluster of symptoms may suggest a specific disorder (syndrome), a number of disorders or no disorder at all.

The history of Parental Alienation

In the early 19th century, American judges became concerned about divorce cases where one parent 'poisoned the mind' of a child against the other (Fidler, Bala & Saini, 2012). However, it wasn't until the 1980s that researchers and practitioners began to record their observations of identified pathological patterns of behaviour in conflicted divorce cases (Johnston & Campbell, 1988; Wallerstein & Blakeslee, 1989; Wallerstein & Kelly, 1980a; Warshak, 2001, 2003). In 1985, Richard Gardner coined the term Parental Alienation Syndrome (PAS) for a type of emotional child abuse, following the observations he carried out in child custody evaluations.

> The Parental Alienation Syndrome 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 indoctrination by the alienating parent and the child's own contributions to the vilification of the alienated parent.
> (Gardner, 1985, p.61).

Gardner's work was criticised for its lack of scientific rigor and its limited peer review: much of his work was self-published, with limited reference to other research or established theory and relied on substantial self-referencing (Gardner, 1992, 1999, 2001). However, several publications largely based on conceptual analysis or clinical practice ensued, supporting the validity of PAS as a concept, though not all were subjected to the peer review process (Bone & Walsh, 1999; Brody, 2006; Kopetski, 1998a, 1998b; Leving, 2006; Lorandos, 2006; Rand, 1997a, 1997b, 2005).

The widening use of PAS as a *de facto* clinical diagnosis in family court cases had drawn wide criticism on the basis that PAS was not included in *DSM-IV* (APA, 1994; Bruch, 2001; Faller, 1998; Kelly & Johnston, 2001; Peris & Emery, 2005; Zirogiannis, 2001). In clarification, Gardner (2003) stated that PAS had not been *rejected* by the *DSM* committee, as no submission for inclusion had been made due to the limited literature available at the time that the contents of *DSM-IV* were being considered. Criticism from mental health professionals and those working with families involved in high-conflict separations seemed broadly concerned with Gardner's suggested aetiology – focusing on parental behaviours, and his proposed extreme interventions – including changing custody and removal of the child from both parents. Kelly and John-

ston (2001) subsequently critiqued Gardner's definition, reformulating PAS with an assessment focus on the child and not on the behaviours of the parent. They coined the term 'alienated child' and posited that PA is not necessarily *caused* by an alienating parent. Rather, it arises as a result of combined systemic processes including environmental, parental and child factors which lead to and perpetuate the alienation of a child from a parent with whom there was previously a normal, loving relationship (Kelly & Johnston, 2001). Gardner concurred with the need for a more systemic understanding of all childhood disorders, including PAS (Gardner, 2001). More recently, Johnston re-visited her definition of the alienated child, implicating the observable and measurable alienating behaviours of the parent which she believes to be emotionally abusive in the alienation process (Johnston, cited in Fidler et al., 2012). Although theories about aetiology vary, Gardner and Kelly and Johnston arrived at almost identical symptoms within the child as features of alienation.

Further criticism of Gardner came from women's advocates (especially for victims of domestic violence) and feminist groups. One argument postulated is that PAS was constructed as a concept to refute the existence of child sexual abuse and to enable the denial of criticisms of a non-custodial parent in court cases (Meier, 2009). Furthermore, in response to allegations of abuse and violence, male perpetrators counter-allege PAS (Walker, Brantley & Rigsbee, 2004). In this feminist narrative, the parental behaviours which Gardner suggests as alienating or brainwashing, are justifiable protective behaviours of a parent against the abuser of a child (Walker & Shapiro, 2010).

The debate for inclusion of Parental Alienation in *DSM-5*

Whilst the concept of PA is acknowledged and is even seen as mainstream in many areas of the world, it remains contentious and continues to be hotly debated. 'There has been controversy among mental health and legal professionals regarding some aspects of parental alienation, and at times the professional discourse resembled the hostility manifested by entrenched and angry parents fighting over their children' (Bernet et al., 2010, p.78). Although there are hundreds of peer-reviewed articles by psychologists, psychiatrists, legal and social work professionals attesting to the concept and presence of PA in highly-conflicted divorce cases, Bruch states that PAS is 'rejected by responsible social scientists and lacks solid grounding in psychological theory or research' (Bruch, 2001, p.550). Whilst accusing proponents of parental alienation disorder (PAD) as possessing a certain 'tunnel vision' in neglecting justifiable reasons for rejection other than alienating behaviours by a parent, Walker and Shapiro (2010) themselves appear similarly blinkered in their denial of such alienating behaviours.

Despite the worldwide debate and the assertion that alienation is almost always alleged when there appears to be no rational reason for a child to reject a parent (Walker & Shapiro, 2010), this does not seem to be the case in the UK. PA has rarely been openly or formally discussed in the UK. Anecdotal evidence suggests that the concept is perceived as 'American twaddle' and is dismissed out of hand by the judiciary, solicitors and Cafcass officers when raised in family proceedings. It is difficult to refute these suggestions due to the closed nature of the UK family courts, whereby disclosure of any court material other than by a judge renders the informant in contempt of court. However, the 'Cafcass Operating Framework' makes clear reference to PA throughout, though there is no indication of the criteria applied in considering whether PA is a factor in cases (Cafcass, 2012). 'Implacable hostility' is a term more often used where alienating behaviours and factors are in evidence in the UK. Despite the anecdotal suggestions of litigants, support groups, campaign groups and lay

supporters in family law cases that PA is disavowed in lower regional family courts, high court judge the Honourable Mr Justice Coleridge (2012) has affirmed the recognition of PA and its damaging effect on children.

The petition

In 2008, a group of 70 mental health practitioners and legal professionals supported a formal proposal for the inclusion of PA to the *DSM-5* Disorders in Childhood and Adolescence Work Group (Bernet et al., 2010). This proposal suggested diagnostic criteria for Parental Alienation Disorder (PAD), a relational disorder, which would enable systematic research, reduce the misuse of the PA concept and lead to improved treatment for children and young people (Bernet, 2008). The feedback received was that further evidence would be required, and welcomed, regarding the validity of PA as a discrete mental condition, its prevalence and the reliability of the proposed diagnostic criteria (Bernet et al., 2010). A more detailed proposal, addressing these areas amongst others, was submitted to both the *DSM-5* Task Force and the *ICD-11* International Advisory Group (Bernet et al., 2010). In relation to *DSM-5*, the proposal suggests that PAD be included in Chapter V of the manual 'Behavioural and emotional disorders with onset usually occurring in childhood and adolescence', or included as an Appendix in 'Criteria sets and axes for further study'. Alternatively, it suggests the inclusion of Parental Alienation Relational Problem in the chapter 'Other conditions that may be a focus of clinical attention' (Bernet et al., 2010).

In defining the criteria for PAD, the petitioners have sought to move away from a causal definition based on parental behaviour to a focus on child behaviours. The essential feature of the proposed diagnostic criteria for PAD is that a child, without legitimate justification, allies himself/herself strongly with one parent whilst rejecting a relationship with the other parent. The primary behavioural symptom is the child's refusal or resistance to contact with one parent, or engagement in contact which is characterised by extreme withdrawal or gross hatred and animosity. The primary psychological symptom is irrational anxiety and/or hostility toward the rejected parent (Bernet et al., 2010).

Validity and reliability

In addressing the Task Force's concerns about the validity of PAD, the petition reported several studies in the 1980s and 1990s in which similar factors were independently identified in populations of children from high conflict relationship breakdowns. Gardner's observations in hundreds of child custody evaluations in the 1970s and 1980s led to his defining eight behaviours or symptoms, generally observed in highly conflicted custody battles, which he suggested were indications of PAS (Gardner, 1992). Gardner emphasised that the child's denigration of the alienated parent is unjustified, unlike in cases of parental abuse or neglect where such animosity is warranted. Unaware of Gardner's work, psychotherapist Leona Kopetski's custody evaluation team arrived at similar conclusions to Gardner. Twenty per cent of their 413 evaluation cases during a 14-year period had dynamics which demonstrated behaviours similar to those of Gardner's PAS characteristics. However, it is difficult to determine the level of similarity as the published article gives insufficient details of the cases and data collected (Kopetski, 1998a, 1998b). Clawar and Rivlin (1991) analysed data in more than 700 cases referred following custody evaluation in a 12-year period. They documented data from children's diaries, direct observations, forensic reports, court transcripts, audio and video recordings of children's interactions with their parents, therapy notes and interviews with children, parents, families and friends, school staff, mental health practitioners and legal professionals. Their findings identified programming behaviours aimed at alienating the child against the

other parent in approximately 80 per cent of cases, and concluded that severe PA resulted from persistent programming and brainwashing.

During a period of 20 years, sociologist Janet Johnston and colleagues studied children who were the subject of entrenched custody disputes. In one study of 44 children aged 6 to 12, she identified six primary responses including a strong alliance in seven children. This alliance was defined as strong and consistent with an overt preference for one parent accompanied by denigration and rejection of the other, accompanied by resolute negativity and hostility (Johnston, Campbell & Mayes, 1985). In further studies of 140 divorcing parents and 175 children involved in entrenched contact disputes, similar effects were identified (Johnston, 1993). Further research contrasted the normal response to divorce with the minority of children who become enmeshed and aligned with one parent and alienated from the other (Johnston & Roseby, 1997).

In long-term studies of 60 divorcing families, psychologist Judith Wallerstein and colleagues identified the 'pathological alignment' of some vulnerable children, often adolescents, with one parent who displayed a level of narcissistic damage and rage related to the relationship break-up. In their enmeshment, the child would collaborate to hurt or punish the other parent with whom they had shared a loving relationship prior to the breakdown of the marriage. The alienating parent would often seek to disrupt contact and suggest, either consciously or unconsciously, that the other parent was dangerous or dislikeable (Wallerstein & Blakeslee, 1989; Wallerstein & Kelly, 1976, 1980b) .

Psychologist Barry Bricklin's study involving thousands of children and parents identified a group of susceptible children who voiced strong opinions about parents, which did not correspond with data from alternative sources. These opinions usually reflected manipulation, bribery or coercion rather than direct experience. The behaviours of one sub-group strongly resembled those detailed in PAS: the child expressed a strong positive opinion of the resident parent and a strong negative opinion of the other parent; a conscious lack of ambivalence towards both parents – one was all good, the other all bad; trivial or irrelevant reasons for disliking the rejected parent (Bricklin & Elliot, 2006).

Subsequent to this independent determination of similar behavioural factors in a subset of children, and Gardner's publication of PAS criteria (Gardner, 1992), researchers and professionals began to consider these factors in samples of children of separated parents. This enabled the identification of children and parents with a defined cluster of symptoms and behaviours. Over the past 20 years, research in the fields of psychology, sociology and family law have identified or corroborated many aspects of PA. Severe PA has been found to be resistant to clinical intervention, independent of length of relationship, to occur immediately after separation or at a later date. It is present in children of all ages. The alienating parent is most usually the parent with custody and alienating behaviours are often unconscious or portrayed in socially acceptable ways. Denigration of the targeted parent and obstructing or interfering with contact is common. There is correlation between the severity of parental alienating behaviours and children's alienation symptoms, whilst contributing behaviours in the targeted parent are minimal. Alienating parents are more likely to use splitting, denial, projective identification and projection as defences in attempts to portray themselves as perfect and without fault (Bakalar & Novak, cited in Bernet et al., 2010; Burrill, 2006; Dunne & Hedrick, 1994; Gordon, Stoffey & Bottinelli, 2008; Nicholas, 1997; Rand, 1997a, 1997b; Siegel & Langford, 1998; Vassiliou & Cartwright, 2001). Although some caution needs to be exercised due the retrospective nature of the study, Baker's (2007) research with adults who identify themselves as having

been manipulated by one parent to reject the other as a child, suggests both substantiation of the PA concept and affirmation of the negative lifelong impact on victims. Similar results were found in Germany (Von Boch-Galhau & Kodjoe, 2006). Research has also identified an exacerbation of alienation in cases involving third parties, such as social care and the legal system. However, the role of effective family court evaluations in ameliorating or reversing the alienation process has also been acknowledged (Correa da Fonseca, cited in Bernet et al., 2010; Burrill, 2006; Rand, 1997b, 2005).

The petitioners propose that these converging results strengthen both the ecological and external validity of a PA concept, or disorder. They suggest that validity is further strengthened by the 'hundreds and perhaps thousands of mental health professionals in North America, South America, Europe, Africa, Australia, and Asia [who] identified the same constellation of symptoms in children of parents who were embroiled in high-conflict divorces' (Bernet et al., 2010, p.100). Furthermore, Baker (2007) found that all 104 custody evaluators who responded to her survey believed that it was possible for one parent to turn a child against the other where there was no suggestion of abandonment, abuse or neglect. Ninety-six per cent of Baker's participants were familiar with PAS, yet 50 per cent of the respondents believed that it should not be included in *DSM-5* (one-third in the later survey). Whilst the dynamic nature and identification of Gardner's eight behaviours was recognised and used in evaluations, controversy around the concept of PA as a syndrome was acknowledged. Seventy-five per cent disagreed with the concept of a syndrome and a lack of research in the area was identified. PA has been explicitly acknowledged by the American Academy of Child and Adolescent Psychiatry though the American Psychological Association maintains that evidence does not support a diagnosable Parental Alienation Syndrome (Bernet et al., 2010).

Although there is much agreement on the behavioural symptoms of PAD, suggesting some level of face validity, there are greater difficulties with construct and predictive validity. One area which seems to present difficulty is the aetiology of PAD. Most controversial is the role of false allegations of violence or sexual abuse as a causative factor. The petition's proposed PAD criteria makes reference to the potential for false allegations, which are factors in much of the published material.

There is some evidence that the incidence of all allegations of sexual abuse in disputes over child custody is minimal (less than two per cent of around 9000 families) and just above that in the normal population (Thoennes & Tjaden, 1990). However, Baker (2007) found that in cases which required custody evaluation, both substantiated and false allegations of sexual abuse were more widely encountered. More than 94 per cent of the professionals surveyed had encountered both true and false allegations in their caseload, with substantiated allegations occurring 44.2 per cent and unsubstantiated allegations 45.1 per cent in some, or many, of their cases. Corresponding figures for PAS are 65 per cent for the presence of PA and 55.3 per cent for false allegations of PA. Faller (1998) critiqued Gardner's contrary assertions that perhaps more than 95 per cent of allegations of child sex abuse are true, yet in divorce cases with custody disputes – the vast majority of allegations are false. Whilst child sexual abuse and domestic violence were keenly investigated during custody evaluations, these were rarely found to be substantiated in cases involving PA (Bow, Gould & Flens, 2009). The petitioners suggest that the clarification of terminology and criteria afforded by the inclusion of PA in *DSM-5* will precipitate a uniform understanding of the concept and reduce its misuse in custody disputes.

The presence of domestic violence in the family and its impact on a child is likely to have bearing on a clear diagnosis. Whilst Walker and Shapiro (2010) acknowledge

that many studies in this area are limited by their retrospective nature, they suggest that many clinicians misinterpret the quantity of data necessary to infer the damaging effects on a child. However, they also reject studies of a similar nature which consider the effects of alienating behaviours by parents.

Johnston (cited in Bernet et al., 2010) rejects both the concept of 'the alienated child' and 'parental alienation' as diagnostic entities. Despite her reported confidence in distinguishing between substantiated and unsubstantiated allegations of abuse, she maintains that it is sometimes difficult in practice to differentiate between unjustified alienation and justifiable estrangement (Johnston, Walters & Olesen, 2005). Namyslowska, Heitzman and Siewierska (cited in Bernet et al., 2010) discount a disorder within the child, conceptualising PA as a specific, dynamic family situation sometimes occurring during conflicted child custody cases. Parental alienating behaviour is not always explicit. A child may become alienated in the absence of overt alienating behaviour, often responding to an unconscious metacognitive message that the other parent is undesirable. Such behaviours may include unvoiced disapproval when talking about the other parent; not allowing talk about the other parent or contact with that parent; withholding affection when contact takes place or a child talks about the other parent; organising special treats at contact times (Fidler et al., 2012).

The alienating parent may not always be acting out of hostility or vindictiveness; they may believe that their perceptions of the other parent are objectively true. In such situations they seek to protect their child and this instigates their alienating behaviour (Kopetski, 1998a). The developmental, cognitive and emotional stage of a dependent child often impacts on their capacity to test reality – to differentiate between external reality and their internal mental world. As such they may unwittingly become an active part of the alienation dynamic.

With regards to the predictive validity of PA, this remains difficult to assess. There is considerable research that indicates detrimental outcome and morbidity especially when PA becomes entrenched and remains unaddressed. Whilst normalising a child's healthy rejection and distancing from a parent who is unreliable, inadequate or abusive, Johnston, Walters and Olesen (2005) found that those children who are alienated have more clinically significant emotional and behavioural problems. Symptoms include poorer self-esteem, more emotional dependency, difficulties with separation and individuation due to enmeshment or splitting, poor social competence, lack of ambivalence and poor reality testing. Compared to non-alienated children, perception and processing of information differs, as do expression of emotions and preferred coping mechanisms.

Long-term effects of PA were investigated by thematic analysis, in a retrospective study of 38 adults who believed that, as a child, they had been turned against one parent by the actions of another (Baker, 2005). Although many positive childhood experiences were recounted, a poor self-regard was identified. This was interpreted in terms of being prevented from mourning the loss of a parent and encouragement to reject or conceal any positive regard for the alienated parent, cutting off and denying a part of the self in the process. Identified problems included low self-esteem and self-loathing, recurring depression in 70 per cent of participants, substance abuse in one-third, lack of trust in selves and others, a higher divorce rate and alienation from their own children in 50 per cent of cases.

Differential diagnosis

The proposal for the inclusion of PA in *DSM-5* acknowledges that PA is just one reason why a child may reject a parent, and includes a range of potential differential diagnoses (Bernet et al., 2010). In the normal developmental process, children may develop a preference for one parent

which may change over time and even oscillate between one and the other depending on developmental stage, conflicting loyalties or adjustment to specific events. However, this would not render a diagnosis of PAD as the rejection is not persistent. Opponents of PAD advise that it is not possible to appropriately differentiate whether a child is alienated from mental disorders such as separation anxiety, specific phobia, PTSD as a result of abuse, a mood disorder or neurological immaturity or dysfunction (Walker & Shapiro, 2010). Similar symptoms to those of separation anxiety disorder may well be seen in PAD, though there is a difference in preoccupation between fears of harm to the primary caretaker and unrealistic beliefs about the level of danger posed by the alienated parent. Similarly, a specific phobia, situational type, may invoke a refusal or rejection response and the hostility, anger and vindictiveness of oppositional defiant disorder could be viewed as the rejection, denigration and lack of guilt found in PAD. Indeed *DSM-5* states that 'Oppositional Defiant Disorder is more common in families in which there is serious marital discord' (APA, 2000, p.101). Whilst the petitioners posit that the cluster of symptoms present in PAD are specific to that disorder, these could reasonably by diagnosed as an adjustment disorder which may be developed in response to divorce, loss of a relationship or family disharmony.

Prevalence

The majority of the peer-reviewed studies considering the prevalence of PA have been conducted in the US. In studies with separating families, custody evaluators, mental health professionals and in community samples, the prevalence of alienating behaviours, or the presence of Gardner's criteria, has been found to be between 20 per cent and 55 per cent (Baker, 2007, 2010; Bow et al., 2009; Kopetski, 1998a). It is more difficult to determine the figures specific to the UK due to closed family courts. Transcripts and judgements are not routinely published, though may be at the judge's discretion in the higher courts.

Treatment

Bernet and colleagues suggest that if PA was an official diagnostic category, familiarity with the condition would increase, improved, more prompt identification would ensue, enabling prevention, earlier intervention and improved outcomes (Jaffe, Ashbourne & Mamo, 2010). In the absence of its inclusion within the *DSM* and the associated clear diagnostic criteria, several practitioners are working on developing structural, behavioural and therapeutic interventions (Baker, 2008; Johnston, Walters & Friedlander, 2001; Sullivan, Ward & Deutsch, 2010; Warshak, 2010). However, Walker and Shapiro seem to suggest that the provision of such intervention is unethical as 'there is no recognised empirically-based treatment or assessment dealing directly with such alienation that meets the psychological standard' (Walker & Shapiro, 2010, p.281). Yet the availability of, or response to, treatment is not necessarily required in the consideration of a new diagnostic category (Kendler et al., 2009). There is a clear need to balance the risks and benefits of any intervention, guarding against inappropriate application by clearly differentiating between justifiable estrangement and alienation (Jaffe et al., 2010).

The developmental needs of a child require careful assessment before selecting an intervention which best meets specific needs, whilst also being appropriate for other family members (Friedlander & Walters, 2010; Johnston, Roseby & Kuehnle, 2009). Although used in some severe cases of PA, interventions to exclude either parent from the child's life are rarely appropriate, often amplifying the intractable contact and depriving the child of any good-enough parenting (Kopetski, 1998a). Bruch highlights the need for an understanding of the limitations of available interventions in high-conflict cases stating that 'overly ambitious efforts with only small chances of success

should be shunned in favor of reducing the child's emotional burdens, respecting the child's fears, and enhancing the child's emotional stability' (Bruch, 2001, p.549).

Ethical considerations

Much of the debate around the inclusion of PA in *DSM-5* surrounds the ethical consideration of labelling a child with a mental disorder when the cause of the child's behaviour and disturbances are not fully understood: the cause may be systemic, developmental or relational (Walker & Shapiro). However, a similar criticism could be levelled at other childhood disorders such as conduct disorder, oppositional defiant disorder and even to separation anxiety disorder where onset may be triggered by relational or systemic trauma (APA, 2000)

Further ethical considerations surround applying non-evidence based interventions to a disorder. Walker and Shapiro (2010) suggest that it is unethical for psychologists to work with PAD, as they cannot possibly be competent in an area that has no scientific or empirical basis. This would suggest that it is only appropriate to work with individuals who have a clear diagnosis of a mental disorder, despite the fluidity of the conceptualisation detailed above. At the same time these authors suggest that there is an ethical requirement to prevent harm where it is reasonably foreseeable and that recommending a child have contact with a parent of whom there is a fear is clearly harmful and unethical. However, this black-and-white stance fails to consider the dynamics in these complex relational situations. It fails to consider an assessment of this fear or to acknowledge that, as in phobic fears, supervised exposure can help manage anxiety and eradicate unreasonable fear. There is also a neglect of consideration of the long-term emotional harm which may be caused by failure to address unjustifiable rejection of a parent (Baker, 2007).

Pathologising and counselling psychology

Diagnosis of a mental of disorder is often a concept that sits uneasily within counselling psychology. On the one hand labelling a client with a diagnosis enables a shared understanding with other professionals of possible aetiology, symptomology, potential perpetuating factors and likely prognosis. Further, such a label can enable clinicians to seek out the most up-to-date evidence and recommendations for treatment. However, counselling psychologists treat people, not disorders. Clients are accepted as they present for therapy. It is their subjective experience that informs their therapy – their social situation, their personal developmental history, their upbringing, their general health, their relationships, their support system, their particular symptoms, their attachment style, their defences, their responsibilities, their culture, their identity – and their diagnosis if they find it relevant. Although an assessment may indicate the presence of a mental disorder, it is not always appropriate to label a client with a diagnosis – careful consideration needs to be given to what such a diagnosis might mean (Gelder et al., 2006). Whilst it could mean a better understanding of their condition and enable them to take ownership, it could also lead to them feeling stigmatised, to adopt a sick role and to situate the responsibility for their recovery firmly outside of themself. Furthermore, if no diagnosis can be made, does this suggest that a client is 'well' – and not deserving of therapeutic intervention? Formulation, specific to each client, addresses many of these concerns, and leads to the development of a personalised treatment plan.

This being the case, how relevant is psychopathology to counselling psychology? As reflective scientific practitioners there is a dual role incumbent upon the profession. Firstly, there is a requirement to work therapeutically with a client, whether a diagnosis exists or not. Secondly, there is a duty to contribute to the knowledge base on mental

health and disorder by means of sharing reflections and case studies, and conducting research activity – whether this results in corroboration or challenges the perceived wisdom at that moment in time.

Conclusion

There has been considerable controversy over PA since the 1980s. There has been debate about whether PA is a disease, a disorder, a syndrome; what factors contribute to its aetiology, what are its manifestations, what is the prognosis. There has been debate over interventions – when to intervene, whether to intervene and how to intervene: with therapeutic support for the child or the family, with structural interventions such as enforced contact or change of residence or with a combined approach. Despite this controversy, Fidler and colleagues (Fidler et al., 2012) suggest there is more agreement than disagreement amongst experienced professionals. Almost all mental health practitioners who have written about PA agree that: PA is one of many causes of contact refusal; contact refusal in the presence of abuse or problematic behaviour does not come under the definition of PA; PA as a concept exists – there are young people who persistently denigrate and refuse to see one parent, and the intensity of this behaviour is disproportionate to any behaviour on the part of the rejected parent. Despite this consensus that alienation exists within a distinct population who would benefit from intervention, some professionals reject the proposal for inclusion in *DSM-5* (Johnston & Kelly cited in Fidler et al., 2012). Rejection of the proposal is based on the substantial overlap of causal factors and behavioural symptoms with normal developmental stages and reactions to family breakdown, as well as other disorders. Further, many cases involve a level of complexity whereby both alienation and justifiable rejection may co-exist: there is no clearly defined line between abusive parenting and poor or marginal parenting (Johnston, cited in Fidler et al., 2012). Bearing this in mind, it is difficult to determine whether the benefits of a diagnosis of PAD outweigh the risks, especially where there may be misdiagnosis due to required expediency. Risk of harm may be further exacerbated due to an increase in conflict following a diagnosis of PAD, which might suggest that one parent was to blame for the situation. Such a diagnosis may be counterproductive in the reparation process.

Whether PAD is included in *DSM-5* or not, as seems likely, the recent debate has highlighted the need for further research. Alienation exists. Despite the current lack of uniform diagnostic criteria, there are cases of unjustifiable rejection of a parent where there has previously been a good, loving relationship. A greater understanding of the processes, symptoms and behaviours involved will enable the needs of children and families involved in high-conflict separation to be better addressed.

About the Author

Sue Whitcombe is a Counselling Psychologist in Training on the Doctoral Programme at Teesside University. She is motivated by her many years of experience working with children and young people and is equally passionate about her clinical work and research. Sue's doctoral research is a Q methodology exploration of parental alienation focussing on the experiences of alienated parents.

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