Parental Alienation Syndrome: What Health Care Providers Need to Know

Deana S. Goldin, PhD, PMHNP-BC, Debra Salani, DNP, PMHNP-BC

ABSTRACT

The consequence of emotional strain on children has been documented along with the connection between deleterious life experiences and undesirable future health trajectories. The emotional maltreatment of children may be the most difficult to identify in clinical practice and is thus underrecognized. With a fundamental mission to promote child health, pediatric and family practitioners are in a perfect position during well-child visits to screen for parent alienation syndrome (PAS), a type of emotional maltreatment experienced by children of divorce or high-conflict parent separation. The purpose of this report is to provide an overview of the PAS construct to providers who are unfamiliar with this syndrome. Additionally, this report aims to alert health care professionals to the features of PAS and support them in identifying children who may require further mental health support services from other members of the health care team.

Introduction

Social changes can directly and indirectly affect children, especially those who experience divorce during their young and impressionable years. Divorce is common in United States (US) culture, and its effect on children can be detrimental to their development and overall well-being.\(^1\) Divorce, which can lead to faulty intrafamily dynamics, may affect children of every ethnic background, religion, and socioeconomic status. The incidence of divorce has continued to rise: the net divorce rate was 14.59\% in 2018.\(^2\) Data regarding the precise number of children affected by divorce annually is difficult to obtain; however, it is estimated to be about 1 to 1.5 million yearly. Approximately one-half of separations (40.7\%) and about one-third (33.1\%) of divorces concern marriages with at least 1 child younger than the age of 18 years.\(^3\)\(^-\)\(^5\)

Divorce is a major life event and is considered an adverse childhood experience, which may impact the child emotionally and physically. Divorce is recognized as one of the most common adverse childhood experiences (ACEs), defined as traumatic events that occur in a child’s life before the age of 18 and may include household dysfunction, trauma, abuse, or neglect.\(^4\)

According to a neural diathesis-stress model, genetic predisposition and environmental influences contribute synergistically to the development of mental and physical disorders. Cumulative toxic stress during a divorce crisis can have long-lasting adverse effects on children and has been shown to induce hypothalamic-pituitary-adrenal and epigenetic changes, with consequent increases in reported rates of adult diseases, including heart disease, stroke diabetes, and depression.\(^5\) Prolonged stress exposure has also been associated with developmental and cognitive delays that can adversely influence a child’s linguistic, academic, and social functioning. Epigenetic changes are a phenomenon in gene expression that can arise from tumultuous environmental stimuli without a change in genotype.\(^6\)

Adults going through a divorce or separation often do their best to protect their children and to help them go through the process unscathed; however, during a divorce and the heightened emotional states associated with it, adults may use children as a mechanism to fulfill their personal wants and needs, such as when one parent feels threatened by the child’s relationship and love for the other parent.\(^7\) This report serves as an introduction to readers not familiar with the parental alienation syndrome (PAS) construct. Furthermore, this report aims to raise awareness among health care professionals by alerting them to the features of PAS and to support health care professionals in identifying children who may require further support services from other members of the health care team.

Background

PAS, a term first coined in 1985 by child psychiatrist Richard A. Gardner,\(^8\) is a phenomenon that occurs during a custody battle in which one parent or caretaker consciously or unconsciously attempts to turn the couple’s child against the other parent.\(^9\) PAS is a psychologic condition caused as a result of one parent (often the one with primary custody) exercising power over the child and preventing the child from coexisting with the child’s other parent. PAS is a mental state in which a child has untrue, illogical,
Table 1
Key Elements of Parent Alienation

A. The Child -
- Allies strongly with one parent (nonalienated parent) who is engaged in a high conflict separation from the other parent (alienated or targeted parent)
- Alienated from the rejected parent through a combination of coercive control and emotionally harmful behaviors
- The child is used as an instrument to harm the alienated parent

B. The Child’s Behaviors
- Rejects a relationship with the alienated parent without legitimate justification.
  - Strong resistance, refusal of contact or parenting with the alienated parent for illogical, untrue or exaggerated reason

C. The Child’s Attitudes (2 of 6)
- Lack of ambivalence
- Absence of guilt or remorse
- Phenomenon of the independent thinker
- Borrowed scenarios and circumstances from alienating parent
- Reflexive support towards alienating parent
- Animosity may extend towards other family members of the alienated parent

D. Alienation towards a parent does not result from child maltreatment.

exaggerated, or unfounded negative feelings against or rejection of one parent due to the influence of the alienating parent.8,10

Parent alienation (PA) is an observable psychologic phenomenon consisting of distinct patterns of odious behaviors displayed by a child who maliciously rejects and directs anger toward a previously loved parent.11 PA can be seen in children whose parents experience a tumultuous divorce or engage in high-conflict disputes, including persistent conflict. PA can arise in the context of a custody dispute where the child exhibits irrational, illogical, and unfounded hatred and engages in intentional malicious behavior toward the noncustodial parent without justification or cause.10 According to Gardner,12 PAS includes 3 key elements: (1) rejection or denigration of a parent that is persistent and not simply an occasional episode; (2) the rejection is unjustified, irrational, or ludicrous, or the alienation is not a reasonable response to the alienated parent’s behavior; and (3) it is a partial result of the nonalienated parent’s influence.

In addition to the 3 key elements of PAS, Gardner also suggests PAS is characterized by 8 distinct elements that the child may display; these elements will be examined as well. Table 1 provides key elements of PA. PAS refers specifically to the behaviors of the child and is a mental state in which a child allies strongly with one parent and experiences PA; however, PAS specifically describes abusive behaviors of a parent who makes a conscious effort to damage or destroy the linkage between the other parent and child.1 The alienating or emotionally abusive parent demoralizes the other parent through the child out of anger and revenge for the demise of the marriage or because of unrelenting feelings of anger toward the other parent.2

PAS involves the programming, conditioning, or indoctrination of the child by one parent against the other parent or caregiver and the child’s denigration of the target parent or caregiver;12 Gardner hypothesized that children are not born with genes that program them to reject a father and that such hatred is environmentally induced, and the most likely person to have brought about by alienation of a parent.13

Gardner12 claimed that PAS is a syndrome, a group of symptoms that consistently occur together characterized by 8 distinct elements:

1. The child unfairly criticizes and displays hatred against the targeted parent and displays a campaign of denigration against the targeted parent described as the refusal expressed by the child to have a relationship with one of the parents.

2. The child provides weak rationalizations for the deprecation and hatred toward the targeted parent.

3. The child uses phrases, terms, or expressions that are not developmentally appropriate and often borrowed from the alienating parent.

4. The child lacks usual ambivalence toward either parent.

5. The child has strong insistence that the decision to reject the parent is the child’s alone (this is called the independent thinker phenomenon).

6. The child’s demonstrates unconditional, automatic support of the alienating parent.

7. The child has significant lack of guilt over the treatment of the of the targeted parent.

8. The child’s denigration also extends to include the extended family of the targeted parent.12

If the alienated parent has been genuinely abusive, the child’s alienation is merited, and PAS would not be considered.14 PAS can fall into 3 classifications: mild, moderate or severe.12 In the mild type, alienation is relatively superficial, and the child cooperates with visitation; however, the child may be overly critical of and disgruntled with the victimized parent. In the moderate type, alienation is more difficult, the child is more disruptive and disrespectful, and the campaign of denigration may be almost continual. In the severe type, the child is hostile (may reach paranoid levels), aimed at causing extreme grief to the alienated parent that can reach the point of physical violence.15

According to Ellis and Boyan,16 the alienating parent typically has signs of a cluster B personality disorder (borderline, narcissistic, antisocial, or histrionic) most commonly associated with overly dramatic, emotional, and unpredictable behaviors, including narcissistic features such as lack of empathy for others.17 Individuals with personality disorders often lack insight, and there are limited treatments available. Therefore, the alienating parent—child dyad becomes enmeshed without appropriate boundaries, thereby making it difficult for the child to develop individuality, which may negatively affect the child’s overall development and functioning.

Barriers to PAS Diagnosis

By the medical definition, a syndrome is a cluster of symptoms, grouped together, that explain or characterize a specific disease manifestation emerging from a basic underlying cause.16 Although researchers have studied PAS for more than 60 years, showing PAS to be a valid and reliable construct, it remains controversial, criticized as being overly simplistic and lacking empirical evidence of construct validity and scientific support.17 According to Siracusano et al.,1 data on PAS should be considered a psychologic trauma,
making it an important risk factor for psychiatric conditions. Risk factors include all theoretic conditions including the child’s environment. Interestingly, PAS is the first condition in the world for which a diagnosis may be concluded without subjective suffering or explicit psychic alterations, therefore, leading to the controversy in conceptualizing the problem for alienated children.6(p.235)

Despite the growing bodies of evidence, PAS continues to raise debate regarding inclusion in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5), despite being accepted as a concept by the DSM-5 task force. The DSM-5 task force concluded that PAS did not meet the standard classification of a mental disorder because it describes a disorder in the relationship between people and not of the individual.10 The DSM-5 task force responded to a request to include PAS with “the requirement that a disorder exists as an internal condition residing within an individual,” and PAS would better be considered an example of a relational problem.10

To date PAS has not been included in DSM-5; however, a code for “child affected by parental relationship distress” (CAPRD) does denote some clinical manifestations of PAS.18 CAPRD is not clearly defined in the DSM-5; however, this category should be used when clinical attention is focused on the negative effects of parental-relationship discord (eg, high levels of conflict, distress, or disparagement) on a child in the family, including effects on the child’s mental health or other medical disorders.17(p.716). The codes for CAPRD are V61.29 in the International Classification of Diseases (ICD) 9th Revision Clinical Modification and 262.898 in ICD 10th Revision—Clinical Modification.

Notwithstanding the lack of formal support, PAS is held to be valid by its supporters and is acknowledged in the legal and mental health communities. Those who acknowledge the veracity of PAS include mental health therapists, health care providers, social workers, law enforcement personnel, lawyers, and judges.20 To date, more than 1000 books, book chapters, and 500 articles have been published in mental health or legal professional journals about PAS.20

Future research is needed using large-scale systematic studies to clarify the specific features of PAS, such as the intensity of the symptoms, timing of onset of symptoms, and duration of symptoms, using clinical data and empirically validated and refined assessment tools. Research to define specific objective diagnostic criteria would serve to refine diagnosis and offer optimal treatment modalities. Lastly, nationwide research is needed to prevent the misuse of the term and concept of PAS in clinical and legal areas.

Screening and Identification of PAS in Children

The prevalence and negative impact of emotional stressors triggered by ACE have been documented along with the connection between a child’s negative life experiences and future health trajectories.14,22 According to Gillespie and Folger,23(p250) excessive tenacious stressors during childhood can result in acute and long-term behavioral and emotional challenges, poor school performance, high-risk behaviors, physical illness, and vast psychologic pathologies. Although children possess a great deal of resilience, stresses during the first 6 years of life can be detrimental to children’s well-being, making carefmg psychosocial history taking a priority in primary care settings.24

Currently, PAS lacks a clear and agreed framework, making the phenomenon difficult to study and detect. Owing to the emerging body of knowledge about the undetected emotional mistreatment placed on children, The National Institute for Health and Care Excellence has included emotional abuse in its published guidelines to help recognize and respond to different types of abuse in children.25 For example, introducing a child to false fears, emotional manipulation, withdrawing of love and affection, and child-isolating behaviors are tactics of abuse used by an alienating parent. Owing to children’s vulnerabilities and inefficient coping skills, high incidences of psychologic disorders have been found in alienated children; therefore, PAS has been linked to a type of psychopathologic trauma that leads to brain alterations and disturbed psychosocial development.13(p.235)

In countless children who have experienced emotional mistreatment, PAS may remain undetected when the parent is responsible for bringing a child’s psychologic issues or concerns to the attention of the health care provider during primary care office visits.18 Because PAS is a phenomenon that is diagnosable and potentially treatable, pediatric wellness visits that include routine anticipatory guidance and parenting counseling may be the ideal venue to assess, identify, and manage PAS as an ACE. The American Academy of Pediatrics recommends frequent primary care visits throughout childhood,25 therefore, primary health care clinicians are well positioned to create positive and supportive relationships with children and their families, especially because the schedule of well-child visits is skewed to more frequent visits during toddlerhood and the preschool years. Additionally, pediatric health care providers may be the first professionals from whom parents seek assistance and openly communicate about the impact of the divorce on their child.5

Implications for Practice

The health and welfare of children depends on the support they receive from their families, leaving pediatric primary care providers responsible for determining policies that guide interventions in the assessment of child abuse and neglect. As a result of the negative impact early emotional and environmental influences may have on children’s psychologic development, the American Academy of Pediatrics task force has created a report (2003)26 that includes the promotion of nurturing families to protect children from harm and informs pediatric providers on their role in the promotion of optimal family functioning.27

Identifying PAS may be especially difficult during the preschool years; however, heightened awareness of the stress that adversarial or high-conflict divorce can produce for children, and its potential to negatively impact child development and self-esteem may encourage health care personnel to consider routine screenings to identify family factors that may adversely affect children and respond to emotional maltreatment, if detected.28,29 Early detection of PAS can expedite interdisciplinary support services for the child and family to better preserve the child’s emotional, behavioral, and interpersonal functioning and allow the child to develop to his or her potential.

Despite disagreement in the literature regarding whether PAS is a syndrome or an intrarelationship disorder, consensus does exist that PA may have long-lasting adverse effects on children’s mental and emotional well-being. It may be challenging for health care providers to screen for PAS due to the lack of empirical evidence and ongoing disagreement regarding a standardized description of PAS. Furthermore, no clinical guidelines have been developed for clinicians to assess, identify, and treat PAS.

A feasible approach to PAS inquiry can include screening children in a targeted manner or over time in the course of a continuous relationship of primary care to a patient and family. Careful observation and detailed medical, social, and psychosocial history taking is useful in screening children for PAS. At yearly visits, the child’s home status and with whom they reside ought to be updated. Health care personnel can explore purposeful, empathetic, patient-centered, and open-ended questions about the child’s feelings, ideas, experiences, and concerns, especially relating
to their own perspective of themselves and their family in the absence of the parent if possible. Additional exploration can include friends, interests, and academic performance, offering information regarding the child's development and overall well-being. It is particularly important to cue into the child's psychosomatic symptoms and behavioral changes if they should develop.

Health care personnel should make general observations of the child's behavior and overall functioning, independent of parental behaviors, examining notable behavioral changes. Does the child exhibit signs of anxiety, fear, and withdrawal? Does the child appear guarded? Not all children will speak freely about their emotional pain; however, the child may exhibit signs of irritability, depression, or withdrawal. If the child comes from a divorced family, it is important to ask the child about their visitation schedule and how they feel about each house. If PA is suspected, health care personnel should inquire about the reason to determine the identifiable cause and appropriateness of the alienation, seeking answers about the basis for the alienation. Situations can arise in which alienation from a parent is warranted, and if this is the case, whether the child is receiving emotional support for that circumstance should be determined.

In cases of PAS, the rejection of a parent is out of proportion to the child’s reasoning behind the rejection. The child's choice of words can thus be informative. For example, health care providers should listen closely to the child’s language and consider the choice of words to determine whether the child is using examples and vocabulary that are age appropriate. Table 2 summarizes best practices to identify PAS. Often children with PAS repeat stories and use terms that come from the alienating parent.17

Treatment options to consider for children and families include therapy services, preferably using a family-systems method, child and adolescent mental health professionals, psychoeducational programs or support groups, school counselors, and family bridge programs created specifically to allow the child to develop relationships with both parents. These programs are designed to improve the child's well-being and protect the child from harm related to the alienation.20 The goal is to detect PAS during the early stages, before the child's self-esteem and self-identity are permanently impacted.1 These steps can provide clinicians with information so they can better refer children to appropriate services.

Key Clinical Points

- PAS, as a form of emotional mistreatment, can lead to physical and psychologic sequelae.
- Educational programs are needed to help health care professionals gain skills in identifying PAS.
- Health care professionals may be able to reduce the emotional and physical health burden associated with childhood stress associated with PAS exposure by identifying and engaging patients with histories of victimization.
- It is necessary to raise public awareness of the seriousness and signs of PAS to optimize children's development, health, and safety.
- Through observation and history taking, pediatric and family clinicians can better identify and refer children and families to appropriate therapy services, preferably using a family-systems method.

Implications for Future Research

Given the variability in legal and clinical definitions of PA, as well as the differences in how PA can be conceptualized, the exact prevalence of PAS is unknown.7 The paucity of research on PAS belies the estimated 3.8 million children in the US who are victims of PA behaviors.26,30 The inclusion of PAS in the next editions of the DSM and ICD can facilitate research by providing definable syndrome patterns and patient-monitor outcomes. Increasing awareness of the PAS in primary care can serve to identify children who meet the criteria for PAS and decrease the prevalence for those where the opportunity of early intervention may have been lost. Furthermore, input from various professions and individuals who work in the mental health and family court arenas is important to determine how to allocate resources for children with PAS.

Conclusion

It is a fundamental right and need of each child to be protected from harm and have unthreatening relationships with their parents.7 The literature supports the negative impact children of PA face when exposed to persistent, unremitting, and intense parental conflict. Intrafamilial pressures such as PA cause children to experience enormous amounts of emotional distress. Heightened clinician awareness of PAS can promote early identification for children, guiding them toward helpful interventions and enhancing interprofessional collaboration among members of the health care team to support children and their families. Although increasing bodies of evidence have emerged on PAS, it is still not officially recognized as a psychologic disorder in the DSM-5; however, health care professionals ought to be mindful of potentially harmful family dynamics that may cause increased amounts of stress for children, impacting their ability to thrive and develop to their full potential.

The accumulation of ACEs throughout childhood, especially during particularly sensitive early developmental periods, may have long-lasting effects on development and overall health into adulthood and may contribute to an intergenerational cycle of recurring ACEs.20 Acquiring an understanding of the link between PAS, trauma, and epigenetics as it relates to the brain development and how these risk factors may contribute to other psychological disorders prepares clinicians to be better positioned to screen...
children. Pediatric primary care health care providers have a core mission to promote the child's physical and psychologic health and are in an ideal position to implement PAS screenings during well-child visits. Informed pediatric primary care providers are well poised to provide mental health support through referrals and to collaborate with other members of the health care team to provide interdisciplinary care to ameliorate the adverse impact PAS can have on a child's overall well-being.29

References


Deana S. Goldin, PhD, DNP, FNP-BC, PMHNP-BC is a clinical assistant professor, FNP Program Leader, at Nicole Wertheim College of Nursing and Health Sciences, Florida International University, Miami, and can be contacted at deangoldin@fiu.edu; Deborah Salani, DNP, PMHNP-BC, is a clinical associate professor and director of the PMHNP Program, University of Miami School of Nursing and Health Studies, Coral Gables, Florida.

In compliance with national ethical guidelines, the authors report no relationships with business or industry that would pose a conflict of interest.