RECOMMENDATIONS FOR DEALING WITH PARENTS WHO INDUCE PARENTAL ALIENATION SYNDROME IN THEIR CHILDREN

RICHARD A. GARDNER

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ABSTRACT: The parental alienation syndrome is commonly seen in highly contested child-custody disputes. The author has described three types: mild, moderate, and severe — each of which requires special approaches by both legal and mental health professionals. The purpose of this article is to correct some misinterpretations of the author's recommendations as well as to add some recently developed refinements. Particular focus is given to the transitional-site program that can be extremely useful for dealing with the severe type of parental alienation syndrome. Dealing properly with parental-alienation-syndrome families requires close cooperation between legal and mental health professionals. Without such cooperation therapeutic approaches are not likely to succeed. With such cooperation the treatment, in many cases, is likely to be highly effective.

THE PARENTAL ALIENATION SYNDROME

The parental alienation syndrome (PAS) is a disorder that arises almost exclusively in the context of child-custody disputes. It is a disorder in which children, programmed by the allegedly "loved" parent, embark upon a campaign of denigration of the allegedly "hated" parent. The children exhibit little if any ambivalence over their hatred, which often spreads to the extended family of the allegedly despised parent. Most often mothers are the initiators of such programming, and fathers are the victims of the campaigns of deprecation. However, in a small percentage of cases it is the father who is the primary programmer and the mother who comes to be viewed as the "hated" parent. Furthermore, we are not dealing here with simple "brainwashing" by one parent against the other. The children's own scenarios of denigration often contribute and complement those promulgated by the programming parent. Accordingly, I introduced the term *parental alienation syndrome* (PAS) to refer to *both* of these contributions to the disorder. Because of the children's cognitive immaturity their scenarios may often appear preposterous to adults. Of course, if the hated parent has genuinely been abusive, then the children's alienation is warranted and the PAS concept is *not* applicable.

There are three type of parental alienation syndrome: mild, moderate, and severe. It goes beyond the purposes of this report to describe in full detail the differences between these three types. At this point only a brief summary, however, is important here. In the mild type, the alienation is relatively superficial and the children basically cooperate with visitation, but are intermittently critical and disgruntled. 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 cause formidable grief to the parent who is being visited. In many cases the children's hostility has reached paranoid levels, that is, delusions of

persecution and/or fears that they will be murdered in situations where there is absolutely no evidence that such will be the case.

Listed below are the primary manifestations of the PAS (Gardner; 1992):

- The Campaign of Denigration.
- Weak, Frivolous, or Absurd Rationalizations for the Deprecation.
- Lack of Ambivalence.
- The "Independent Thinker" Phenomenon.
- Reflexive Support of the Loved Parent in the Parental Conflict.
- Absence of Guilt over the Denigration and/or Exploitation of the "Hated" Parent.
- The Presence of Borrowed Scenarios.
- Spread of the Animosity to the Friends and/or Extended Family of the Hated Parent.

This article has been written because of certain misinterpretations of the recommendations I made in my book on the PAS. Although these recommendations are situations in which they have not been implemented in the appropriate manner, sometimes with unfortunate and even disastrous results. In addition, I present here certain refinements I have come to appreciate since the publication of the original book in 1992. (These are summarized in Tables 1 and 2.)

Because mothers are much more often alienators than fathers, I will refer to the parent who induces the PAS as the mother, and the parent who is the victim of the child's campaign of denigration as the father. Obviously, in situations in which the father is the one who is inducing the PAS in the child and the mother the victim of the campaign of denigration, then the recommendations made here for the mother should be applied to the father.

Unfortunately, the term *parental alienation syndrome* is often used to refer to the animosity that a child may harbor against a parent who has actually abused the child, especially over an extended period. The term has been used to apply to the major categories of parental abuse, namely, physical, sexual and emotional. Such application indicates a misunderstanding of the parental alienation syndrome. The term is applicable only when the parent has not exhibited anything close to the degree of alienating behaviour that might warrant the campaign of denigration exhibited by the child. Rather, in typical cases the parent would be considered by most examiners to have provided normal loving parenting or, at worst, exhibited minimal impairments in parental capacity. It is the *exaggeration* of minor weaknesses and deficiencies that are the hallmarks of the parental alienation syndrome. When bona fide abuse does exist, then the child's responding hostility is warranted and the parental alienation syndrome diagnosis is *not* applicable.

TABLE 1: Differential *Diagnosis* of the Three Types of Parental Alienation Syndrome.

	MILD	MODERATE	SEVERE
Primary Symptomatic Manifestation			
The Campaign of Denigration	Minimal	Moderate	Formidable
Weak, Frivolous, or Absurd Rationalizations for the Deprecation	Minimal	Moderate	Multiple absurd rationalizations
Lack of Ambivalence	Normal Ambivalence	No Ambivalence	No Ambivalence
The Independent-Thinker Phenomenon	Usually Absent	Present	Present
Reflexive Support of the Loved Parent in the Parental Conflict	Minimal	Present	Present
Absences of Guilt	Normal guilt	Minimal to no guilt	No guilt
Borrowed Scenarios	Minimal	Present	Present
Spread of the Animosity to the Extended Family of the Hated Parent	Minimal	Present	Formidable, often fanatic
Transitional Difficulties at Time of Visitation	Usually absent	Moderate	Formidable or visit not possible
Behaviour During Visitation	Good	Intermittently antagonistic and provocative.	No visit or destructive and continually provocative behaviour throughout visit
Bonding With Mother	Strong, healthy	Strong, mildly to moderately pathological	Severely pathological, often paranoid bonding
Bonding With Father	Strong, healthy, or minimally pathological	Strong, healthy, or minimally pathological	Strong, healthy, or minimally pathological

TABLE 2: Differential *Treatment* of the Three Types of Parental Alienation Syndrome.

	MILD	MODERATE	SEVERE
Legal Approaches	Court ruling that primary custody shall remain with preferred parent.	Plan A (Most common) 1. Court ruling that primary custody shall remain with the preferred parent. 2. Court appointment of PAS therapist* 3. Sanctions: a. Money b. House arrest c. Incarceration Plan B (Occasionally necessary) 1. Court ruling that primary custody shall be transferred to the alienated parent. 2. Extremely restricted visitation by the preferred parent, under supervision if necessary, to prevent indoctrinations.	1. Court-ordered transfer of primary custody to the alienated parent (in most cases). 2. Court-ordered transitional site program**
Psychotherapeutic Approaches	None usually necessary	Plan A (Most common) Treatment by a court appointed PAS therapist* Plan B (Occasionally necessary) Therapist monitored transitional site program.	Therapist monitored transitional site program**

* Gardner, R. A. (1992), *The Parental Alienation Syndrome*, Cresskill, NJ: Creative Therapeutics, Inc. pp. 230-245.
** _____ (1992), *The Parental Alienation Syndrome*, Cresskill, NJ: Creative Therapeutics, Inc. pp. 334a-334h.

Programming parents who are accused of inducing a parental alienation syndrome in their children will sometimes claim that the children's campaign of denigration is warranted because of bona fide abuse and/or neglect perpetrated by the denigrated parent. Such parents may claim that the accusation of parental alienation syndrome induction is merely a "cover-up," a diversionary maneuver, an attempt on the part of the vilified parent to throw a smoke screen over the abuses and/or neglect that have justified the children's campaign. There are indeed some genuinely abusing and/or neglectful parents who will deny their abuses and rationalize the children's campaign of hatred as being programmed by the other parent. This does not preclude the existence of truly innocent parents who are indeed being victimized by a parental-alienation-syndrome campaign of denigration. When such cross-accusations occur — namely, bona fide abuse and/or neglect vs. a true parental alienation syndrome — it behooves the examiner to conduct a detailed inequity in order to ascertain the category in which the children's accusations lie, i.e., true parental alienation syndrome or true abuse and/or neglect. In some situations, this differentiation may not be easy, especially when there has been some abuse and/or neglect and the parental alienation syndrome has been superimposed upon it — resulting in far more deprecation than would be justified in this situation. It is for this reason that detailed inequity is often crucial if one is to make a proper diagnosis. Combination of individual and joint interviews with the children and parents is probably the best way to make this important differentiation.

In recent years some professionals use the term PAS to refer to a false sex-abuse accusation in the context of a child-custody dispute. In some cases the terms are used interchangeably. This is a significant misperception of the PAS concept. In the majority of cases in which a PAS is present the sex-abuse accusation is not promulgated. In some cases, especially after other exclusionary maneuvers have failed, the sex-abuse accusation will emerge. The sex-abuse accusation, then, is most often a spin-off, or derivative, of the PAS and is in no way synonymous with it. Furthermore, there are divorce situations in which the sex-abuse accusation may arise without the PAS present. Under such circumstances, of course, one must give serious consideration to the possibility that true sex abuse has occurred, especially if the accusation antedates the marital separation.

Before one can make a decision regarding legal and therapeutic approaches to the PAS child it is important that a proper diagnostic evaluation be conducted in order to ascertain specifically in which category the child's symptoms lie: mild, moderate, or severe. *Each type warrants a very different approach.* Failure to make this discrimination may result in grievous results, with significant psychological trauma to all concerned parties. This principle is in line with the ancient medical tradition that proper diagnosis must precede treatment. Furthermore, evaluators should appreciate that the category of PAS is not determined by the efforts of the programming parent, but by the degree to which the indoctrinating attempts have been successful. It is the resultant PAS manifestations in the child that determine the categorization, no the degree of parental efforts at indoctrination. A mother, for example, may embark upon a relentless campaign, the purpose of which is to denigrate the father to the degree that the child will hate him formidably. However, the father's love and involvement with the child has been deep-seated. Accordingly, the mother's efforts may not prove successful, so strong has the father's bonding been. And the older the child the less likely her efforts will be successful.

MILD CASES OF PAS

Manifestations

Children in the *mild* category exhibit relatively superficial manifestations of the eight primary symptoms: campaign of denigration; weak, frivolous, or absurd rationalizations for the deprecation; lack of ambivalence; the "independent thinker" phenomenon; reflexive support of the loved parent in parental conflict; absence of guilt; the presence of borrowed scenarios; and spread of the animosity to the extended family of the hated parent. Most often only a few of these eight symptoms are present. It is in the moderate type, and especially in the severe type, that most, if not all of them are seen. Visitation is usually smooth with few difficulties at the time of transition. Once in the father's home the children's primary motive in contributing to the campaign of denigration is to maintain the stronger, healthy psychological bond that they have developed with their mothers.

Legal Approaches

In *mild* cases of PAS all that is usually needed is the court's confirmation that the mother will remain the designated primary custodial parent. In such situations the PAS is likely to alleviate itself without any further therapeutic or legal intervention.

Psychotherapeutic Approaches

Most often, psychotherapy for PAS symptoms in the mild category is not necessary in that they are likely to disappear once the court makes a decision to designate the mother the primary custodial parent. However, psychotherapy *might* be necessary for other problems attendant to the divorce.

MODERATE CASES OF PAS

Manifestations

The *moderate* cases are the most common. It is in this category that the mother's programming of the child is likely to be formidable and she may utilize a wide variety of exclusionary tactics. All eight of the primary manifestations are likely to be present, and each is more advanced than one sees in the mild cases, but less pervasive than one sees in the severe type. The campaign of denigration is more prominent, especially at transition times when the child appreciates that deprecation of the father is just what the mother wants to hear. The children are less fanatic in their vilification of the father than those seen in mild cases. None of the normal ambivalence that children inevitably have with regard to each of their parents is present. The father is described as all bad and the mother as all good. The child professes that he(she) is the sole originator of the feelings of acrimony against the father. The reflexive support for the mother in any conflict is predictable. The child's absence of guilt is so great that the child may appear psychopathic in his (her) insensitivity to the grief being visited upon the father. Borrowed-scenario elements are likely to be included in the child's campaign of denigration. Whereas in the mild category there

may still be loving relationships with the father's extended family, in the moderate cases these relatives become viewed as clones of the father and are similarly subjected to the campaigns of revulsion and denigration.

Whereas in the mild cases transition times present few difficulties, in the moderate cases there may be formidable problems at the time of transfer, but the children are ultimately willing to go off with the father, while their mother's purview, the children generally quiet down, relax their guard, and involve themselves benevolently with their fathers. This is in contrast to the severe category where visitation is either impossible or, if the children do enter the father's home their purpose is to make his life unbearable by ongoing vilification, destruction of property, and practically incessant provocative behavior. The primary motive for the children's scenarios of denigration is to maintain the stronger, healthy psychological bond with the mother.

Legal Approaches

1. In *moderate* cases I still recommend that the mother remain the primary custodial parent, her inducement of the PAS in her children notwithstanding. In moderate cases, she has usually still been the primary parent with whom the children have been mostly deeply bonded and it therefore makes sense for her to continue in this role. A court order finalizing this arrangement can contribute somewhat to the alleviation of the PAS, but it is not likely to evaporate entirely the symptoms, so deeply have they usually become entrenched by the time of this order.

2. Because in most cases the court has decided that the mother will remain the primary custodial parent, there is continued resistance to visitation. This is the result of the entrenchment in the brain-circuitry of both mother and children that the father is somehow despicable. Accordingly, a court-ordered therapist is often necessary who serves to monitor visits, use his (her) office as a transition site, and report to the court any failures to implement visitation. This therapist *must* be someone who is knowledgeable about the PAS and comfortable using the special, stringent therapeutic approaches necessary for successful alleviation of symptoms in both parents and children.

3. In most cases, recalcitrant mothers need to be warned by the court that if the children do not visit with the father, for whatever reason, court sanctions will be imposed. These not only serve to "remind" the recalcitrant mother to cooperate with visitation but are very useful for the children as well. It gives them the excuse to visit and can assuage the guilt they might otherwise feel if they were to admit to their mothers that they themselves want to see the father. In such situations the child can say to the mother: "I really hate him, and I don't want to visit with him. However, if I don't see him, I know the judge will punish you." I cannot emphasize strongly enough this important factor in the efficacy of sanctions, and even threatened sanctions.

I generally recommend that the first level of such sanctions be financial, e.g., reduction of alimony payments. If this does not serve to bring about visitation, then house arrest for short periods should be ordered by the court. At the first level of house arrest, the woman would

merely be required to remain in her home throughout the prescribed time frame of the "sentence," with none of the traditional monitoring by police. Generally a "sentence" of a few days will suffice, e.g., the time frame of a child's weekend visitation. The woman should be put on notice that if during that time frame she will be arrested. If this fails, then a more formal arrangement should be made with electronic transmitters placed on the woman's ankle and telephone calls from the police to the home, randomly made throughout the 24-hour time frame. If , then actual incarceration for limited periods should be utilized. I am not recommending that these women be placed in prison with hardened criminals. I am only suggesting short periods in a local jail. In most cases, the awareness of financial penalties and the possibility of incarceration is enough to motivate such mothers to get their children to the father's home, their resistance to such visits notwithstanding. Unfortunately, my experience has been that courts are not generally willing to impose these sanctions, and so mothers in the moderate category have not been meaningfully deterred from continuing the promulgation of a PAS in their children.

My general recommendation to courts is that they use the same methods that they would for a father who reneges on alimony and support payments. Although financial penalties are not usually imposed under such circumstances, short prison terms (especially on weekends), both at home and in jail, have proven quite effective. Inducing a PAS in a child is a form of child abuse, more specifically emotional abuse. Reneging on alimony and support payments is also a form of child abuse, in that from the privations generated by such withholding. The court has the power to induce both types of child abusers to reconsider their ways, and courts can do this much more speedily and effectively than can therapists.

Psychotherapeutic Approaches

It is important that the court order treatment by someone who is not only familiar with the PAS but who is comfortable using the stringent approaches necessary for order. The therapist monitors visits, uses his (her) office as a transitional site, and reports to the court any failures to implement visitation. Without direct access to the court and without meaningful sanctions that the court is committed to implement is likely to fail. Details of this therapeutic program are provided on pages 230-245 of my Parental Alienation Syndrome book (Gardner, 1992).

In most cases of moderate PAS the aforementioned program should prove efficacious. However, success depends upon the joint efforts of both the court and the PAS family's therapist. If the court fails to invoke sanctions (a common occurrence) and/or a therapist does not satisfy the aforementioned provisos of treatment (also a common occurrence), then there is little likelihood of reduction of the children's symptoms. They may then progress on to the severe category. In such situations, the only hope of protecting the children from progression to the severe category — and the likelihood of lifelong alienation — is to transfer primary custodial status to the father. Such transfer; however, should only be done in situations in which the mother's programming is so deep-seated and so chronic that it is obvious that sanctions *and* a special PAS therapeutic program will prove futile. An example of such a situation would be one in which the mother is clearly paranoid, refuses to cooperate at all in the special therapy, and it becomes clear that incarceration is not going to in any way affect her delusion. Under such circumstances, transfer of custody is necessary in order to protect the children from progressing down the road to the severe type of PAS and ultimate disintegration of the father-child bond. Following transfer,

varying degrees of maternal access to the children are possible, depending upon the mother's ability to reduce the PAS-inducing manipulations. Supervised visitations with the mother are often indicated in order to protect the children from her indoctrinations. This is similar to the monitoring provided for abusing fathers. After all, inducing a PAS in a child is a form of abuse from which children need protection.

We have, then, two types of custodial plan for the mother who programs children into the moderate level of PAS. The majority, whose tendencies are not deep-seated and longstanding, may respond to the sanctions and special PAS therapeutic program. Such mothers, in my experience, represent the majority of programming mothers in the moderate category. There are a minority of such mothers, however, whose programming tendencies are so chronic and deep-seated that sanctions and the special therapeutic program have either proven futile or there is every indication that they are doomed to failure. Under such circumstances it is necessary to prevent the children from to a severe PAS. These two situations Plan B in Table 2.

SEVERE CASES OF PAS

Manifestations

Children in the *severe* category are usually fanatic. They join together with their mothers in a *folie à deux* relationship in which they share her paranoid fantasies about the father. All eight of the primary symptomatic manifestations are likely to be present to a significant degree than in the moderate category. Children become panic-stricken over the prospect. Their blood-curdling shrieks, panicked states, and rage outbursts may be so severe that visitation is impossible. If placed in the father's home they may run away, become paralyzed with morbid fear; or may become so continuously provocative and so destructive that removal becomes necessary. Unlike children in the moderate and mild categories, their panic and hostility may not be reduced in the father's home, even when separated from their others for significant periods. Whereas in the mild and moderate categories the children's primary motive is to strengthen the stronger, healthy bond with the mother (often paranoid) and the symptoms serve to strengthen the pathological bond.

Legal Approaches

In *severe* cases of PAS, which represent a very small minority of PAS cases (approximately five-to-ten percent in my experience), more stringent measures *must* be taken. If there is any hope of alleviating the children's symptom the first step must involve a transfer of physical custody to the home of the father. Whether this remains permanent depends upon the behavior of the mother. Because the children typically will not cooperate regarding going to the father's home, the therapist may be confronted with one of the knottiest problems I have encountered regarding the treatment of PAS families. Specifically, my recommendation that the court remove such children from the home of a parent who is inducing a severe type of PAS (especially when paranoia is present) has not been met with receptivity by judges and some mental health professionals.

One source of this unreceptivity relates to the deep-seated notion that children should not be removed from their mother, no matter how disturbed she may be. (As mentioned throughout this article, for simplicity of presentation, I refer to the programming parent as the mother because she, much more often than the father, is the programmer. However, the same principles apply when the father is the primary promulgator of the PAS.) Courts have generally been much more receptive to my recommendations for the mild and moderate categories of mothers, because my recommendations do not include removal of the children from the mother's home. Another source of unreceptivity relates to the fact that the children in the severe category are often so frightened of their father, and have been so imbued with the notion that being in his home is dangerous and might even be lethal, that transfer is considered impossible. My frustration, resulting from the unreceptivity of courts to implement this recommendation, has been made especially poignant by the recognition that the children's remaining in the mother's home dooms their relationship with their father and predictably results in their developing longstanding psychopathology, even paranoia.

An intermediary disposition, an arrangement that does not involve immediate transfer from the home of the mother to the home of the father, can solve many of the problems attendant to a direct transfer and can also reduce judicial unreceptivity to this proposal.

Before describing the details of the transitional program, it is important to emphasize that the transition points are particularly difficult for PAS children. In such circumstances, with both parents present, the children's loyalty conflict is most acute. In the case of children suffering with the severe type of PAS, transition under such circumstances is practically impossible. The father is generally unable to get the children out of the mother's home and, even if they are transferred to his home by force, they are likely to run away and do everything possible to return to their mother's home. Temporary placement in a transitional site appears to be an excellent solution to this problem. In such a transitional site, the aforementioned confrontation is obviated in that the children are not placed in a position in which they are with both parents together.

It is also important to reiterate that mothers in the severe category are not going to comply readily with court orders to cease and desist from their brainwashing. In fact, their ignoring of court orders is one of the reasons why they warrant placement in the severe category. The main purpose of the program presented here is to enforce the mother's separation from the children pending upon the case-in order to protect the children from the mother's ongoing campaign of manipulation and programming. Accordingly, during this early phase it contact at all between the children and their mother, either or indirectly, e.g., via telephone or mail. All these contacts will be utilized by the mother to continue her brainwashing and will thereby lessen significantly the likelihood that this traditional program will be successful.

The Three Levels of Transitional Sites

There are three levels of transitional restrictive from the least restrictive to the most restrictive environments. The less restrictive environments should be tried first, using the most restrictive as a lass resort — and then only if the less restrictive facilities do no prove adequate for the purposes of the transfer. The program must be monitored by a guardian ad litem or court-appointed therapist who serves to monitor the program and who also has direct access to

the court for judicial support and the issuing of court orders necessary for the success of the plan. Without such "clout" the program is not likely to succeed. For each level of transitional site there is a phased program, the purpose of which is to facilitate the children's transfer from the mother's to the father's home.

Site Level 1. In this category of transitional site, I include the home of a friend or relative with whom the children have a reasonably good relationship. Although this might be the home of one of the father's relatives, it would not be a suitable place for transition if the mother has been successful in programming the children to believe that these individuals are part of the father's extended network of people who will also cause them significant harm. While living with these people, arrangements have to be made for the children's attending a local school. In order to serve effectively, these caretakers have to appreciate the depth of the mother's pathology and have to be strong enough to prohibit mail and telephone calls (during a prescribed period — see below) and report to the proper authorities (e.g., a guardian ad litem or a court-appointed therapist) the failure of the mother to obey the court order restraining her from visiting the children or even coming into their neighborhood or school. The caretakers at this site would also have to be able to exert control over the children's antics during the periods of their father's visits with them (see below).

Another type of transition site in this category would be a foster home. Here, again, the foster parents would have to satisfy the aforementioned criteria of vigilance and stringency.

If the situation is so bad that a level-1 transitional site is not feasible, then a more restricted environment must be considered. This would be necessary if the mother continued to ignore court orders not to call or visit the children (either in the transitional home or in the school environment). It would also be necessary if the children continued to run away from a level-I transitional site in order to return to their mother. Under such circumstances, a level-2 transitional site would have to be considered.

Site Level 2. A possible site in this category would be a community shelter—the kind of setting where are placed delinquents, abandoned children, abused children, and others warranting removal from their homes. It is preferable that the school be incorporated into this facility (sometimes the case). Here there would be much more stringent surveillance and control of the children's behavior, especially when the father visits (see below), as well as the mother's potential to visit and/or communicate with the children.

This facility might not prove feasible if the children's antics became unmanageable, if the mother continues to visit the premises (in spite of a court order), and/or if the children's behavior becomes uncontrollable at the time of the father's visits. Under those circumstances, a level-3 transitional site would have to be considered.

Site Level 3. Hospitalization. Obviously, this is the most restrictive environment, one in which there is the greatest degree of control over the situation. This should only be tried after transitional sites 1 and 2 have been considered and, preferably, tried. Obviously, here the children would at least opportunity to go back to their mother's home, and there would be the greatest degree of control over the children's behavior at the time of the father's visits. It is crucial that the treating personnel have knowledge of the PAS and the opportunity for input to the court, either directly or indirectly. Because most hospitals have affiliated schools, the children could attend school while hospitalized.

The Six Phases of Transition at Each Site

At this point I will address myself to the details of the six-phase sequence developed to effect a transfer from the mother's home to the father's home via the transitional site. Although the program may be under the auspices of a therapist, what is done here is far less therapy than "movement of bodies". The main goal is to provide the children with living experiences that their father is not the terribly dangerous person he has been portrayed to be by the mother. The ultimate aim is to get the children into the father's home as soon as possible, but it is important to recognize that the amount of time spent in the transitional site will vary from case to case, and transfer must be monitored carefully by the people involved in administering the transitional program. I propose a program that follows this sequence:

Phase 1. Placement in the transitional site. Here, the children are removed from the mother's incessant campaign of programming, yet they are not with their father, with whom they believe terrible things will happen to them. During this period at the transitional site, all contact with the mother should be cut off, including mail and telephone calls. Then, after a few days of accommodation to the new site, the father should visit the children at the site. There, they will start to have the living experience that no harm will come to them. Over the next few days or weeks (depending upon their tolerance), visits with the father (again at the site) should increase in both frequency and duration.

Phase 2. At some point (hopefully in a short period), the children should begin visiting their father for short periods in his home, after which they return directly to the transitional site. Gradually, the visits to the father's home should be lengthened, until the point where they can start living there on an ongoing basis. During this period there should be no contact with the mother, even via mail and telephone calls.

Phase 3. The children are discharged from the transitional site and live with their father on an ongoing basis. In the early part of this phase, once again, no mail or telephone calls from the mother should be allowed. If she is seen in the area of the father's home, this is to be reported immediately (through proper channels) to the court, after which serious sanctions, such as a fine, a reduction in alimony payments, and even incarceration (or hospitalization [in selected cases]) should be seriously considered. The children require the living experience that the terrible

consequences that they have anticipated will not be realized. Any interruption of this process by the mother is likely to cause them to regress.

Phase 4. Carefully monitored contact with the mother can be permitted — on a trial basis. The first step should be limited and monitored telephone conversations. It is not likely that the mother will reduce her programming, but at least limitations can be placed on it. If it appears that she has enough self-control and/or that her obsession with brainwashing the children is somewhat under control, longer telephone conversations can be permitted. During this phase, similarly monitored mail communications may be allowed.

Phase 5. Monitored visits with the mother in the father's home may be tried, the frequency and duration determined by how much she can reduce inculcation of animosity toward the father.

Phase 6. In some cases, carefully monitored and judiciously restricted visits to the mother's home might be tried. Obviously, this would only be possible in those situations in which the mother's animosity has become reduced to the degree that there is only limited risk of programming (which runs the risk of undoing all the benefits the previous phases of the program). There are some cases in which this phase would never be reached because the mother might kidnap the children, refuse to return them, or otherwise subject them to unrelentless programming against the father. It is to be hoped, however, that this does not prove to be necessary and that some contacts with the mother might be possible.

Further Comments on the Transitional Site Program

The transitional-site program might be conducted under the auspices of a psychologist, psychiatrist, or guardian ad litem, who is court appointed and who has the freedom to report back to the court any problems that may arise. In recent years, courts have become increasingly appreciative of the importance of strong sanctions (fines, garnisheeing of wages, attachment of property, and even incarceration) for fathers who have failed to fulfill their financial obligations to their former wives. Courts, however, have not been equally receptive to recommendations that PAS mothers know that they cannot ignore the court's order with impunity. The threat of fine and incarceration can help most such women "cooperate." Another issue relevant here is the power of the court to hospitalize the children. Courts certainly hospitalize insane people and/or individuals who are a danger to themselves and others. Many people are committed for shorter periods, such as thirty days. Pending a final decision of the court regarding their permanent disposition. A similar procedure could be utilized to hospitalize PAS children, and a thirty-day limit would, I suspect, be adequate to achieve the aforementioned goals.

Community shelters and psychiatric hospitals are not famous for their plushness. In fact, many are referred to as "zoos," and this reputation is sometimes warranted. However unfortunate this situation may be in other circumstances, it may serve to speed up the transfer program for PAS children. Recognizing that they cannot return to their mother and appreciating that their antics may prolong their stay in the transitional site, may enhance their motivation to move rapidly into

the home of their father. And even the level-I transitional site may serve this purpose if it is inhospitable enough for the children. I am not recommending that one go out of one's way to select the most inhospitable sites for these children; but I am not recommending that one search for the most plush arrangements either.

To date, I have had little direct experience with this proposal, mainly because of the unreceptivity of courts to implement it. Others, however, have described some success with it. I recognize that this proposal, like many of the other proposals in life, are more likely to be put into effect if there are financial resource to support it. This is no different from any other recommendation made in psychiatry, or in medicine in general. The facts are that the more money available for any program (medical or otherwise), the greater the likelihood it will be implemented and the greater the likelihood of its success. To the degree that community and/or personal resources are available to implement this program, to that degree is it likely to prove successful.

It is crucial to reiterate that the only hope these children have for bonding with their father and being protected from the induction of their mother's severe psychopathology is permanent transfer to the home of the father and his designation as the primary custodial parent. Without such transfer, the bonding with the father is inevitably going to be destroyed, and the children will predictably develop the mother's psychopathology. This plan is not designed for PAS families in the mild and/or moderate categories. Mothers in these categories generally have healthier bonding with their children, have most often been the primary caretakers, and (their antics notwithstanding) still warrant being designated the primary custodial parent. Accordingly, no such transfers are indicated for mothers in the mild and moderate categories.

It is not the purpose of this program to preclude the mother entirely from the children's lives. In fact, as described therein, it provides for expanding opportunities for access, depending upon the degree to which the mother can reduce her PAS-inducing indoctrinations. In most cases there will ultimately be varying degrees of maternal access, depending upon the mother's ability to reduce the PAS-inducing manipulations. Supervised visitations with the mother are often indicated in order to protect the children from her indoctrinations. This is similar to the supervision provided for abusing fathers. After all, inducing a PAS in a child is a form of abuse from which children need protection. The transitional program does not necessarily preclude the mother ultimately reverting back to the status of primary custodial parent, although this is not likely in the severe category because these mothers often suffer with significant psychiatric disturbances. It is important to emphasize that it is only in the severe cases of PAS (again, representing five-to-ten percent of cases) that primary custodial status should be shifted from the mother to the father.

Psychotherapeutic Approaches

The transitional site program should be monitored by a therapist who is not only familiar with the PAS but is comfortable with the kind of stringent approaches necessary for the implementation of the transitional site program. In short, this therapist must have the same qualifications as the therapist ordered by the court to implement the treatment of families in the

moderate category. If the therapist does not have these qualifications, the transitional site program is not likely to succeed.

CONCLUDING COMMENTS

The differential diagnostic and treatment approaches to the PAS are summarized in Tables 1 and 2. I cannot emphasize strongly enough that evaluators should never lose sight of the crucial medical dictum: *diagnosis before treatment.* Evaluators from non-medical disciplines tend to lose sight of this important principle. One wants one's heart or brain surgeon to conduct the proper examinations and tests *before* opening up one's heart or head to operate. Most would not submit to such a procedure without diagnostic evaluations and tests. Yet, evaluators and courts are implementing PAS recommendations that are improper for the particular diagnostic category.

I cannot emphasize strongly enough the importance of accurately defining the category of PAS *before* implementing any therapeutic or legal measures. Not to do so is likely to result in grievous errors that will predictably cause significant psychiatric disturbances in all concerned parties. I have seen reports of mental health professionals and courts dealing with mild or moderate cases of PAS as if they were severe, injudiciously and erroneously, then, transferring custody to the father, and even putting women in jail whose level of indoctrinations are minimal and might even be reversed once they had the assurance that they would remain the primary custodial parents. I have seen cases in which courts and mental health professionals have assessed PAS on the basis of the mother's indoctrinations, and not the degree to which the programming process has been successful in the child. In such cases the children may have exhibited only mild PAS manifestations, but the mother was treated as if the children were in the severe category and thereby deprived of custody.

Again, the *diagnosis* of PAS is not made on the basis of the programmer's efforts but the degree of "success" in each child. The *treatment* is based not only on the degree to which the child has been alienated but also on the mother's degree of attempted indoctrinations. In most cases the mother will still remain the primary custodial parent. It is only when she cannot, or will not, inhibit herself from such indoctrinations that custodial transfer and the transitional site program should be implemented. Not to do so will predictably bring about progressively more pathological levels of PAS symptomatology in the children.

It is only in the *severe* category that custodial transfer from the mother to the father will generally be indicated. In *some* cases of moderate PAS, however; such transfer might be necessary because of the mother's deep-seated compulsion to indoctrinate the children against the father and the real danger that she will not desist from her indoctrinations after the trial. Often the main reason why these moderate PAS children have not progressed to the severe category is the healthy input from the father. In such cases, the transitional site program is not necessary because the children are still visiting with their father, although they may be causing him grief in association with their moderate levels of PAS.

In my experiences, it is rare that custodial transfer is warranted in the mild cases. However, the examiner should still consider such transfer for mothers who are so fanatic that it is unlikely they will desist from their indoctrinations after the trial. The only reason why the children are only in the mild category is that the programming has not "taken" probably because of the father's healthy input.

Obviously, the presence of a PAS is only one consideration in assigning primary custodial status. Other factors must be considered, but the presence of a PAS — especially with regard to its level — is crucial if one is to make a proper custodial recommendation in families where it is present.

REFERENCE

Gardner, R. A. (1992) The parental alienation syndrome: A guide for mental health and legal professionals. Cresskill, NJ: Creative Therapeutics, Inc.

Richard A. Gardner, MD, is Clinical Professor of Child Psychiatry, Columbia University, Collect of Physicians & Surgeons, New York City.

This article is an elaboration of a recent addendum to Dr. Gardner's original work, *The Parental Alienation Syndrome: A Guide for Mental Health Professionals* (1992). Dr. Gardner has requested that readers working in this area of PAS with case experience and clinical data contact him at 155 County Road, P.O. Box 522, Cresskill, NJ 07626-0522.