ARTICLES

COMMENTARY ON KELLY AND JOHNSTON'S "THE ALIENATED CHILD: A REFORMULATION OF PARENTAL ALIENATION SYNDROME"

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In a previous issue of this journal, Joan B. Kelly and Janet R. Johnston describe their reformulation of the parental alienation syndrome (PAS). Here, I present areas in which I agree with the authors and areas in which I disagree. Particular focus is placed on these PAS-related issues: the syndrome question, PAS versus parental alienation, the medical model, custodial transfer, gender bias, *DSM-IV*, empirical studies, and the misapplication of PAS.

Keywords: *divorce; child custody; disputes; parental alienation syndrome; family; divorce difficulties in*

In their reformulation of the parental alienation syndrome (PAS), Kelly and Johnston (2001) described a model that overlaps a great deal with my own work on PAS but also differs in a few aspects. Although separated by a continent, I believe we are essentially seeing the same kinds of psychological problems, as divorce is ubiquitous, and similar problems are caused everywhere for the families involved. I believe we could also agree that all solutions to psychological problems have drawbacks and that we are not dealing with right answers and wrong answers, but have to select what we consider to be the least detrimental of the options available to us. Our differences are probably not as wide as the July 2001 issue might imply (for a similar view, see Warshak, 2001), and it is my hope that this response will serve to narrow these differences. Furthermore, because the PAS arises so frequently in the context of litigated child-custody disputes, and because such families turn to the courts for assistance in the resolution of these conflicts, professional differences are likely to become exaggerated and more polarized in the courtroom, which is an inevitable outcome of adversarial proceedings.

IS PAS A SYNDROME?

The authors take issue with my position that the PAS justifies the term *syndrome*. A syndrome, by definition, is a cluster of symptoms, appearing together, that characterizes a specific disease (Campbell, 1989). The symptoms, although seemingly disparate, warrant being

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grouped together because of a common etiology or basic underlying cause. Furthermore, there is a consistency with regard to such a cluster, in that most (if not all) of the symptoms usually appear together. In the early phases, only one or two symptoms may be present. However, over time, more symptoms may appear, ultimately resulting in the full cluster manifesting itself. An example would be Down syndrome, which includes mental retardation, mongoloid-type facial expression, drooping lips, slanting eyes, short fifth finger, and atypical creases in the palms of the hands. There is a consistency here, in that people who suffer with Down's syndrome often look very much alike and most typically exhibit most, if not all, of these symptoms. The common etiology of these disparate symptoms relates to a specific chromosomal abnormality. It is this genetic factor that is responsible for linking together these seemingly disparate symptoms.

Campbell's *Psychiatric Dictionary* (Campbell, 1989) describes three levels of progression toward the recognition of a syndrome. At the *first* level, there are isolated signs or symptoms without apparent linkage to one another. Examples would be headache, psychological tension, stuttering, and constipation. These are isolated symptoms with many possible causes and treatment modalities.

At the *second* level, a clinical picture is formed by the grouping of specific signs and symptoms into a distinctive syndrome. Down syndrome would, again, be an example. The fact that the symptoms occur together is one of the hallmarks of the syndrome, even though all may not be present in the milder forms.

The *third* level is the identification of a particular pathological process or causative agent that brings about the particular constellation of symptoms.

With regard to the PAS, we have gone past the first level: isolated signs and symptoms with no particular relevance to one another. Evidence that the second level has been reached is found in the work of more than 175 authors who have published at least 147 articles on PAS in peer-review journals (Gardner, 2003a). Since Kelly and Johnston also describe the cluster of symptoms seen in alienated children, they too have clearly recognized the level two symptom complex. Although we differ with regard to what to call the cluster, its etiology, where it fits into the broader scheme of psychological problems that result from divorce and its management, we are observing the *same cluster* (Warshak, 2003). Accordingly, it is reasonable to conclude that the second level has been reached.

With regard to the third level, the particular pathological processes or causative agents that bring about this particular constellation of symptoms, we are more in agreement than in disagreement. We agree that a programming process *can* be operative and that the child contributes to the symptom complex. Our area of disagreement relates to the frequency of the programming or alienating parent as the primary causal agent and whether it is useful to think in terms of one primary causal agent.

I view the programming parent to be primarily responsible for the creation of the disorder in the child, and if the programming did not take place, the disorder would not have arisen (for a similar view, see Clawar & Rivlin, 1991). This does not mean that some children are more susceptible and some less susceptible, nor does it mean that other factors may not be operative in the child such as anger over the divorce being directed toward one parent or adolescent rebellion fueling the anger. Of course, I fully recognize that these sources of parental alienation can exist independently, and alongside of, the PAS. However, I still hold that these additional factors are contributory and that the primary cause of the disorder is the programming parent who hopes to gain leverage in court by indoctrinating a campaign of denigration into the child against a good, loving parent. I maintain that a primary causal agent, then, has been identified. Kelly and Johnston do not deny the programming process as one possible

causative agent. If they agree to that, then they may agree that the third level has been reached, that is, the identification of at least one causative agent.

Further verification that the third level has been reached is the aforementioned PAS articles in peer-review journals, whose authors consider the parental programming to be the primary etiological factor. Reviews and discussions of this literature can be found in Ellis (2000), Rand (1997a, 1997b), and Warshak (1999). Kelly and Johnston note that many of my publications on PAS were self-published and have not benefited from peer review. It is important to clarify that this is true only of my books and not of the 19 articles I have written that have been published in peer-review journals. The fact that my books have not gone through formal peer review is not justifiably a valid indictment of PAS. Very few books go through the type of peer review characteristic of scientific journals, including the 16 books I wrote that were published by prestigious publishers such as Jason Aronson and Doubleday.

Furthermore, on my website are citations from 74 courts of law in the United States (21 states), Canada (7 provinces), Australia, Germany, Great Britain, and Israel that have recognized the PAS (Gardner, 2003b). Most of these rulings consider the programming parent to be responsible, and the courts have ruled accordingly, instituting custodial transfer, and/or restriction of access, and/or supervised visitation. Accordingly, I believe that the third level has been reached, and this has been recognized by many legal and mental health professionals who work with families of divorce.

Interrater-reliability studies are needed to help resolve the controversy over the term *syndrome*, but those who hold that we cannot properly use the term *syndrome* until such studies have been completed are requiring a standard not yet satisfied by *most* of the diagnoses in *DSM-IV*. This statement may come as a surprise to many readers, but most of the diagnoses accepted into *DSM-IV* have not been validated by interrater-reliability studies. Still, one could argue that we must wait until such studies are conducted, even though *DSM-IV* is flexible in this regard. My argument against such delay is that there is an immediate need for utilization of the *syndrome* term because of its importance in courts of law. The use of the term *PAS* requires the identification of the programmer, who must be dealt with properly if these children are to be helped. Dropping the term *syndrome* and using simply *parental alienation* (see below) is too vague, lessens the likelihood that the programmer will be identified, and reduces the probability that proper steps will be taken to protect the children from the alienating parent's influence.

PAS VERSUS PARENTAL ALIENATION

I am in full agreement with the authors that there are a wide variety of causes for children's becoming alienated from their parents, including abuse (physical, verbal, emotional, and sexual), neglect, parental abandonment, and adolescent rebellion (Garber, 1996; Gardner, 1998; Lund, 1995; Warshak, 2002a, 2002b). All these are sources of *parental alienation*. PAS is one specific *subtype* of parental alienation, the subtype that is primarily caused (or at least initiated by) a programming parent. I concur that for the forms of alienation that Kelly and Johnston describe in the first half of their article, the PAS diagnosis does not apply. It is not until they write about highly conflicted divorces that the PAS diagnosis becomes viable as a subtype of these other sources of alienation.

The history of science (including medicine, psychiatry, and psychology) is, in part, the history of increasing discrimination—the recognition that what is considered a single entity in one generation may be recognized as having many different subtypes in the next. When

the entity is a disease, each subtype is likely to require a different therapeutic approach. We do not want our doctor to make the diagnosis of *heart disease*, as was the case a few hundred years ago. We want her or him to tell us exactly which subtype of heart disease we are suffering, for example, acute myocardial infarction, subacute bacterial endocarditis, congestive heart failure, and so on. Using *PAS* instead of *parental alienation* increases the likelihood that the programming parent will be identified in the courtroom.

Furthermore, Johnston and Kelly claim that by using *PAS*, I have narrowed my focus and am not properly appreciative of the wide variety of other causes for children's alienation. I first began seeing PAS in the early 1980s. Prior to that time, I had many publications describing many other sources of children's alienation, both within and beyond the field of divorce (Gardner, 1971, 1973, 1974, 1975, 1976a, 1976b, 1978a, 1978b, 1978c, 1978d, 1979a, 1979b, 1979c, 1979d, 1982a, 1982b, 1982c, 1983). The authors' reformulation, especially with regard to the expansion of the causes of alienation—to which they assert I am not giving proper attention—is in fact addressed in the above publications. Accordingly, there is no basis for the criticism that I ignore abuse as a causative factor in children's alienation from a parent. Moreover, a full chapter of my PAS book (Gardner, 1998) is completely devoted to the differentiation between bona fide abuse and PAS, as is a more recent publication (Gardner, 1999). I am certainly aware of the phenomenon by which bona fide abusers try to exonerate themselves by claiming that the children's alienation is the result of PAS indoctrination and not the abuser's own reprehensible behavior. Although the authors' reformulation is of theoretical value, it is not as forceful in a court of law, which must, by necessity, focus on specific statements, symptoms, behavior, and diagnoses. Because PAS usually emerges in the context of litigated child-custody disputes, and because courtroom proceedings are enlisted in the hope of resolving this dispute, the PAS term is far preferable to parental alienation or the more general formulations described by the authors. Elsewhere, I have elaborated upon the parental-alienation-versus-PAS issue (Gardner, 2002a).

PAS AND THE MEDICAL MODEL

Johnston and Kelly criticize me for using the medical model. The central principle of the medical model is that the physician compares the patient's symptoms with those of other individuals with many different kinds of diseases. The physician then tries to ascertain which disease(s) provide the closest "fit" to the signs and symptoms presented by the patient. All those who use *DSM-IV* compare the patient being evaluated with the list of symptoms described for each of the disorders included in *DSM-IV.*

PAS AND CUSTODIAL TRANSFER

The authors state in the preface to their article that PAS involves "the overly simplistic focus on the brainwashing parent as the primary etiological agent." It is true that I do focus on the brainwashing parent, but I do not agree that such focus is "overly simplistic." The fact is that when there is PAS, the primary etiological factor *is* the brainwashing parent. And when there is no brainwashing parent, there is no PAS (Warshak, 2002a, 2002b). This does not mean that all alienated children have brainwashing parents. What this means is that there is a subcategory of alienated children who do have brainwashing parents. When there is a pri-

mary cause, it is useful to label it as such. Such identification is as crucial to PAS as is the identification of the causative agents of all other diseases. Once the cause is identified, a course of action is more readily delineated. Denying the etiological agent significantly compromises one's ability to treat PAS families and to make proper recommendations to courts of law, which, in some moderate and most severe cases, involves restriction of the programmer's access to the children. Reducing the alienator's access or changing custody (in severe cases) helps protect the alienated child.

My follow-up study of 99 PAS children with whom I had direct involvement, along with earlier studies, provides compelling evidence for the effectiveness of such restrictions (Gardner, 2001a). In that study, the court chose to either restrict the children's access to the alienator or change custody in the cases of 22 of the children. There was a significant reduction or elimination of PAS symptomatology in all 22 of these cases. This represents a 100% success rate. The court chose not to transfer custody or reduce access to the alienator in 77 cases. In these cases, there was an increase in PAS symptomatology in 70 (90.9%). In only 7 cases (9.1%) of the nontransferred was there spontaneous improvement. These findings are consistent with those of three previous studies (Clawar and Rivlin, 1991; Dunne and Hedrick, 1994; Lampel, 1986).

In their reformulation of the PAS, Kelly and Johnston claim that their focus is on the alienated child and that I erroneously focus on the alienating parent. Actually, I use the child as a starting point. I see a typical constellation of symptoms: (a) the campaign of denigration; (b) weak, frivolous, or absurd rationalizations for the deprecation; (c) lack of ambivalence; (d) the "independent-thinker" phenomenon; (e) reflexive support of the alienating parent in the parental conflict; (f) absence of guilt over cruelty to and/or exploitation of the alienated parent; (g) presence of borrowed scenarios; and (h) spread of the animosity to the extended family and friends of the alienated parent. The authors see the same symptoms and have described them in their publications.

Most of these symptoms are seen in the moderate cases, and all are usually seen in the severe cases. When these symptoms are present in the child, I look back into the family to ascertain the cause: It is usually a programmer. When one sees *another* constellation of symptoms of alienation—for example, symptoms of abuse (physical, verbal, emotional, or sexual) and neglect—one usually sees *other* causes of alienation having little, if anything, to do with PAS programming. I articulate this point here to demonstrate that I make a determination of PAS only *after* the entire family picture is considered, much as Kelly and Johnston advocate in their reformulation. Indeed, my approach has always been on the *whole* family, with particular focus on protecting children from pathological family influences (Gardner, 1975, 1986, 1988, 1992).

THE PAS AND THE PRIMARY PARENT DESIGNATION

First, I wish to make it clear that I do not automatically recommend that courts transfer custody from the alienating parent to the target parent. As can be seen in Table 1, the recommendation for custodial transfer is made not primarily on the symptoms in the child but on the alienator's symptom level. This is an important point. The *diagnosis* of PAS is made primarily on the symptomatic manifestations *in the child.* By contrast, the recommendations regarding restriction of the alienator's access are made on the basis of the degree of severity of the attempts made by the alienating parent to program the child.

For alienators in the mild category, I usually recommend that the child remain with the alienating parent. For PAS children at the moderate level, when the alienator is also at the moderate level, I generally recommend that the children remain with the alienating parent but that the court warn the alienating parent of the imposition of sanctions if she or he does not cease and desist from attempting to alienate the child (Plan A in Table 1). When children are in the moderate level and the alienator is in the severe level, I do recommend custodial transfer (Plan B in Table 1). For children in the severe level and alienators in the severe level, I recommend a transitional site program, which ultimately results in gradual expansion of the children's contact with the alienated parent and, ultimately, transfer to the alienated parent's home. I make these recommendations only after many hours observing and evaluating the child's symptoms and the parents' behavior and refining the distinctions observed. The position, then, that I automatically recommend custodial transfer in most, if not all, cases of PAS has no validity.

THE PAS AND ALLEGED GENDER BIAS

The authors state (p. 249) that I have written that the indoctrinating parent is usually the mother. This was certainly the case during the 1980s and well into the 1990s. Clawar and Rivlin's (1991) study of 700 PAS families provides compelling evidence of the gender disparity that existed then. However, in the past few years, I have noted a gender shift, so that at this point I consider fathers and mothers to be equal with regard to the percentage of cases in which parents are alienators (Berns, 2001; Gardner, 2001b). Accordingly, those who deny and/or discredit the PAS are depriving mothers who are victims of their husband's PAS indoctrinations (an increasingly frequent phenomenon) of the most powerful weapon they can possibly use in a court of law to defend themselves, namely, the PAS explanation for the children's alienation. The husband's lawyer, almost invariably, welcomes any opportunity to discredit the PAS and argue before the court: "Your honor, everyone agrees that these children are alienated. All you have to do is listen to the children, and it will be obvious that they are alienated from their mother because of her neglect and abuse. The mother is claiming that she is the victim of the father's PAS indoctrinations. Your honor, PAS is an outdated theory." The mother and her lawyer recognize that if the court accepts as valid the arguments of the father's lawyer, the court will not then take seriously the mother's claim that the father is a PAS indoctrinator. The court will "believe the children" and possibly deprive a dedicated, loving mother of primary custody (Gardner, 2002b).

In the period when mothers were more likely than fathers to be PAS indoctrinators, those who recognized PAS risked being labeled as biased against women and "sexist." Also, the equation "PAS equals bias against women" has carried over now into the era when men are equally likely to be PAS indoctrinators. Unfortunately, the dictum is deeply embedded in the minds of many in the legal and mental health professions. In the past, denial of PAS became a weapon for women who were PAS indoctrinators. Now that men are equally likely to be PAS indoctrinators, the deniers of PAS are hurting women who are victims of their husbands' PAS indoctrinations. Moreover, these victimized mothers cannot even turn to the women's rights groups who are still stridently taking the position that PAS does not exist and that PAS is not a syndrome (Heim et al., 2002).

PAS AND *DSM-IV*

Kelly and Johnston state that the PAS is not to be found in *DSM-IV* (American Psychiatric Association, 1994) because "there is no commonly recognized or empirically verified pathogenesis, course, familial pattern, or treatment selection." First, PAS is not to be found in the 1994 edition of *DSM-IV* because at the time it was being prepared (1990-1993), there were too few articles in the scientific literature to justify a submission. Their statement implies a submission and rejection; there was never even a submission. The *DSM-V* is scheduled for publication in 2010. Committees are scheduled to start meeting in 2006. As mentioned, there are at least 147 articles (by over 175 authors) on the PAS in peer-review journals and 74 citations from courts of law in which the PAS has been recognized.

Furthermore, in November 2000, after a Frye hearing, a court of law in Florida concluded that PAS has received such widespread acceptance in the scientific community that it warrants admission in courts of law (*Kilgore v. Boyd*).[1] This ruling was subsequently upheld by a Florida Court of Appeals (*Boyd v. Kilgore*).[2] In January 2002, a court in DuPage County, Illinois, ruled that the PAS satisfied the Frye criteria for admissibility (*Bates v. Bates*).[3] In August 2002, a criminal court in Durham County, Ontario, Canada, ruled that the PAS satisfied Mohan requirements for admissibility (*Her Majesty the Queen v. KC*).[4] The Mohan test is the Canadian equivalent of the Frye test, but it has additional criteria and is more stringent. These lists of peer-reviewed articles and legal citations will be included when a submission on the PAS is proposed to the *DSM-V* committee.

PAS AND EMPIRICAL STUDIES

With regard to the authors' statement that there is no "empirically verified pathogenesis," it is necessary to first define the word *empirical*. *Merriam Webster's Medical Desk Dictionary* (1993) defines *empirical* as "originating in or based on observation *or* [italics added] experiment. Capable of being confirmed, verified, or disproved by observation *or* [italics added] experiment."

Accordingly, the word *empirical* has two different definitions. One definition involves direct patient observation. The other involves experiment. With regard to the first, doctors traditionally publish articles describing empirical studies in which they make some generalizations about small numbers of patients. In certain situations, they may even describe empirical findings on one or two patients. The rationale for this is that patients are suffering now, and we cannot wait until all the definitive scientific studies are done before instituting treatment. The *Journal of the American Medical Association* (*JAMA*) recently published an article describing 22 cases of anthrax acquired by patients from anthrax spores in their mail (Inglesby et al., 2002). The signs and symptoms of these 22 patients were described. *JAMA* published this article without statistical studies. The study is empirical in the first sense of the word. By publishing this article, *JAMA* departed from its traditional format of publishing primarily the second category of empirical studies, namely, studies based on experiment, especially with statistical analyses. Anthrax is a very rare disease, and little was known about its signs and symptoms. This article was the most comprehensive published to date about the signs and symptoms of anthrax, and it was clearly published to help doctors diagnose the disorder if an epidemic arose.

The word *empirical* is also used to refer to studies done in association with scientific experiments, especially those with statistical analyses. Most of the diagnoses in *DSM-IV* have *not* been subject to validity studies or interrater-reliability studies. They have been accepted into *DSM-IV* on the basis of empirical studies at the first level. This is typical when a new disorder is described. All but one of the articles that have thus far been published on the PAS are best viewed as empirical studies at the first level. My follow-up study of 99 children is the only PAS study I know of that subjects the data to statistical analysis and thus justifiably warrants the designation of level-two-type empirical study (Gardner, 2001a). PAS children cannot wait until that remote time in the future when there will be more level-two studies. Decisions have to be made now, along with recommendations to courts of law.

THE MISAPPLICATION OF PAS

The authors, with justification, note that PAS is often misapplied. However, they consider such misapplication to justify their recommendation that the term not be used. There are, indeed, abusing parents who claim that the children's alienation has nothing to do with their abuses but is rather the product of the children's being programmed into PAS by the other parent. With increasing recognition of the PAS, more parents are availing themselves of this exculpatory maneuver. It has become so widespread a problem that in my 1998 PAS book, I devoted a chapter to the differentiation between PAS and bona fide abuse/neglect (Gardner, 1998). In addition, there are mental health professionals who do not properly make the diagnosis, sometimes with disastrous results for the family. These misapplications are unfortunate, but it is illogical to blame them on the disorder or the person who first introduced the term and described its etiology, pathogenesis, clinical manifestations, and treatment. We do not blame Henry Ford for automobile accidents, nor should we dispense with cars because of them.

CONCLUDING COMMENTS

In conclusion, I agree with Kelly and Johnston that the sources of alienation they describe in the first half of their article are not related to PAS. The second half of the article—dealing with high-conflict divorce and the resulting pathologies of all parties—is the cross-over between their reformulation and PAS, and therein are many areas of agreement as well. I do maintain, though, that the diagnosis of PAS is valid for the reasons delineated in this response. It is crucial to refine and discriminate among the signs and symptoms of children's alienation, and the PAS is an effort to clarify and explicate one important subtype of children's alienation.

TABLE 1

	THE CHILD'S SYMPTOM LEVEL		
	MILD	**MODERATE**	**SEVERE**
Legal Approaches	***For Alienators in the Mild Level*** Court ruling that primary custody shall remain with the alienating parent	**Plan A** ***For Alienators in the Moderate Level*** **(Most Common)** 1. Court ruling that primary custody shall remain with the alienating parent 2. Court appointment of PAS therapist[1,2] 3. Sanctions: a. Post a Bond b. Fines c. Community Service d. Probation e. House arrest f. Incarceration **Plan B** ***For Alienators in the Severe Level*** **(Occasionally Necessary)** 1. Court ruling that primary custody shall be transferred to the alienated parent 2. Court appointment of PAS therapist[1,2] 3. Extremely restricted visitation by the alienating parent, monitored to prevent indoctrinations	***For Alienators in the Severe Level*** 1. Court ruling that primary custody shall be transferred to the alienated parent 2. Court-ordered transitional-site program
Psychotherapeutic Approaches	None usually necessary	**Plans A and B** Treatment by a court-appointed PAS therapist[1,2]	Transitional-site program monitored by court-appointed PAS therapist[1,2]

NOTES

1. Kilgore v. Boyd, 13th Circuit Court, Hillsborough County, FL, Case No. 94-7573, 733 So. 2d 546 (Fla. 2d DCA 2000), Jan. 30, 2001.

2. Boyd v. Kilgore, 773 So. 2d546 (Fla. 3d DCA 2000) (*Prohibition Denied*).

3. Bates v. Bates, 18th Judicial Circuit, Dupage County, IL, Case No. 99D958, Jan. 17, 2002.

4. Her Majesty the Queen v. K.C. Superior Court of Justice, Ontario, County of Durham, Central East Region, Court File No. 9520/01, Aug. 9, 2002 (Mohan Test).

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Berns, S. (2001). Parents behaving badly: Parental alienation syndrome in the family court—Magic bullet or poisoned chalice. *Australian Journal of Family Law, 15*(3), 191.

Campbell, R. J. (1989). *Psychiatric dictionary* (6th ed.). New York and Oxford: Oxford University Press.

Clawar, S. S. & Rivlin, B. V. (1991). *Children held hostage: Dealing with programmed and brainwashed children.* Chicago: American Bar Association.

Dunne, J., & Hedrick, M. (1994). The parental alienation syndrome: An analysis of sixteen selected cases. *Journal of Divorce and Remarriage, 21*(3/4), 21-38.

Ellis, E. M. (2000). *Divorce wars: Interventions with families in conflict.* Washington, DC: American Psychological Association.

Garber, B. D. (1996). Alternatives to parental alienation: Acknowledging the broader scope of children's emotional difficulties during parental separation and divorce. *New Hampshire Bar Journal,* 51-54.

Gardner, R. A. (1971). *The boys and girls book about divorce.* New York: Bantam Books.

Gardner, R. A. (1973). *Understanding children: A parents guide to child rearing.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1974). Psychological aspects of divorce. In S. Aireti (Ed.), *American handbook of psychiatry* (Vol. 1, 2nd ed., pp. 496-512). New York: Basic Books.

Gardner, R. A. (1975). *Psychotherapeutic approaches to the resistant child.* New York: Jason Aronson.

Gardner, R. A. (1976a). *The parents book about divorce.* New York: Doubleday.

Gardner, R. A. (1976b). Children of divorce: Legal and psychological considerations. *Journal of Clinical Child Psychology, 6*(2), 3-6.

Gardner, R. A. (1978a). *The boys and girls book about one-parent families.* New York: Putnam.

Gardner, R. A. (1978b). Guidance for separated and divorced parents. In L. E. Arnold (Ed.), *Helping parents help their children* (pp. 279-291). New York: Brunner/Mazel.

Gardner, R. A. (1978c). Social, legal, and therapeutic changes that should lessen the psychological trauma of divorce. *Journal of the American Academy of Psychoanalysis, 6*(2), 231-247.

Gardner, R. A. (1978d). Children's reactions to a divorced parent's new sexual companions. *Medical Aspects of Human Sexuality, 12*(3), 65-66.

Gardner, R. A. (1979a). *The parents book about divorce.* New York: Bantam Books.

Gardner, R. A. (1979b). Intergenerational sexual tensions in second marriages. *Medical Aspects of Human Sexuality, 13*(8), 77.

Gardner, R. A. (1979c). Marital problems. In J. Noshpitz (Ed.), *Basic handbook of child psychiatry* (Vol. 4, pp. 253-263). New York: Basic Books.

Gardner, R. A. (1979d). Divorce. In J. Noshpitz (Ed.), *Basic handbook of child psychiatry* (Vol. 4, pp. 263-270). New York: Basic Books.

Gardner, R. A. (1982a). *The boys and girls book about stepfamilies.* New York: Bantam Books.

Gardner, R. A. (1982b). Joint custody is not for everyone. *The Family Advocate, 5*(2), 7-9. American Bar Association.

Gardner, R. A. (1982c). *Family evaluation in child custody mediation, arbitration, and litigation.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1983). *The boys and girls book about one-parent families.* New York: Bantam Books.

Gardner, R. A. (1986). *Psychotherapeutic techniques of Richard A. Gardner.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1988). *Psychotherapy with adolescents.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1992). *Psychotherapeutic techniques of Richard A. Gardner* (rev. ed.). Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1998). *The parental alienation syndrome* (2nd ed.). Cresskill, NJ: Creative Therapeutics.

Gardner, R. A. (1999). Differentiating between the parental alienation syndrome and bona fide abuse/neglect. *The American Journal of Family Therapy, 27*(2), 97-107. Retrieved from http://www.rgardner.com/refs/ar1.html

Gardner, R. A. (2001a). Should courts order PAS children to visit/reside with the alienated parent? A follow-up study. *The American Journal of Forensic Psychology, 19*(3), 61-106. Retrieved from http://www.rgardner.com/refs/ari.html

Gardner, R. A. (2001b). The recent gender shift in PAS indoctrinators. *News for Women in Psychiatry, 19*(4), 11-13. Retrieved from http://www.rgardner.com/refs/gender.html

Gardner, R. A. (2002a). Parental alienation syndrome vs. parental alienation: Which diagnosis should evaluators use in child-custody litigation? *The American Journal of Family Therapy, 30*(2), 101-123. Retrieved from http://www.rgardner.com/refs/ar10.html

Gardner, R. A. (2002b). The denial of parental alienation syndrome (PAS) also harms women. *The American Journal of Family Therapy, 30*(3), 191-202. Retrieved from http://www.rgardner.com/refs/ar13.html

Gardner, R. A. (2003a). Articles in peer-review journals and published books on the parental alienation syndrome (PAS). Retrieved from http://www.rgardner.com/refs/pas_peerreviewarticles.html

Gardner, R. A. (2003b). Court rulings specifically recognizing the parental alienation syndrome in the US and internationally. Retrieved from http://www.rgardner.com/refs/PAS_LegalCites.html

Heim, S., et al. (2002). *NOW family court report.* Available from California National Organization for Women, 926 J St., Suite 424, Sacramento, CA 95814, http://www.canow.org.

Inglesby, T. V., O'Toole, T., Henderson, D. A., et al. (2002). *Journal of the American Medical Association, 287*(1), 2236-2252.

Kelly, J. B., & Johnston, J. R. (2001). The alienated child: A reformulation of parental alienation syndrome. *Family Court Review, 39*(3), 249-265.

Lampel, A (1986). Post-divorce therapy with high conflict families. *The Independent Practitioner, Bulletin of the Division of Psychologists in Independent Practice, Division 42 of the American Psychological Association, 6*(3), 22-26.

Lund, M. (1995). A therapist's view of parental alienation syndrome. *Family & Conciliation Courts Review, 33*(3), 308-316.

Merriam Webster's Medical Desk Dictionary. (1993). Springfield, MA: Merriam-Webster.

Rand, D. C. (1997a). The spectrum of parental alienation syndrome (Part I). *American Journal of Forensic Psychology, 15*(3), 23-51.

Rand, D. C. (1997b). The spectrum of parental alienation syndrome (Part II). *American Journal of Forensic Psychology, 15*(4), 39-92.

Warshak, R. A. (1999). Psychological syndromes: Parental Alienation Syndrome. In R. Orsinger (Ed.), *Expert Witness Manual.* Austin: State Bar of Texas Family Law Section.

Warshak, R. A. (2001). Current controversies regarding parental alienation syndrome. *American Journal of Forensic Psychology, 19*, 29-59.

Warshak, R. A. (2002a). *Divorce poison: Protecting the parent-child bond from a vindictive ex.* New York: Regan Books.

Warshak, R. A. (2002b). Misdiagnosis of parental alienation syndrome. *American Journal of Forensic Psychology, 20*, 31-52.

Warshak, R. A. (2003). Bringing sense to parental alienation: A look at the disputes and the evidence. *Family Law Quarterly, 37*(2), 273-301.

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