Parental Alienation: Case Series from India

Priyanka P. Nambiar[1], Kavita V. Jangam[1] and Shekhar P. Seshadri[2]

Over the last two decades in India, the issue of marital breakdown has become a common social phenomenon. Researchers have studied its impact on a child's mental health and found issues related to emotional, social, and academic functioning.[1,2] Besides these, an emerging phenomenon that mental health professionals (MHPs) have observed in these families is that following the parental separation, the child spitefully rejects and disparages one of the parents with whom they previously shared a healthy relationship. Though from a child-centric stance one may conclude that the child's preference must be considered, there is a need to explore the underlying reasons for the child's abrupt hostility towards the vilified parent.

The large body of western literature around this phenomenon has termed it Parental Alienation (PA).[2,3] In 1985, Dr Richard Gardner, a child psychiatrist who evaluated children in child custody cases, was the first to coin the term "Parental Alienation Syndrome," wherein he observed common characteristics of alienation and denigration of a parent by the child. He defined it as a syndrome where one parent (alienator) distances the child from the other parent (alienated) by engaging the child in a series of manipulation techniques to denigrate the other parent, primarily observed in the context of child custody disputes in family courts.[4] Gardner proposed that children with PA will manifest these distinct characteristics: (a) "Campaign of denigration" against the alienated parent with whom the child previously shared a healthy relationship; (b) "Unfounded rationalization" given for the hostility and hatred displayed; (c) "Dichotomy of parents," wherein the child idolizes one parent and rejects the other without any ambivalence; (d) "Independent-thinker" phenomenon wherein the child defends that the thought behind the disparaging behaviors are one's own and not induced by the alienator; (e) "Automatic love" and support for the alienator and unwillingness to accept the alienated parent; (f) "Absence of guilt" over maltreatment of the alienated parent; (g) "Borrowed scenarios" wherein the child uses phrases that are age-inappropriate or beyond the child's ability to recall and thereby seems to be coached by alienator; (h) "Generalization of animosity" by mistreating and rejecting the family and friends of the alienated parent.[5]

Despite its occurrence, PA has not been researched in the Indian context. The Supreme Court of India's 2017 judgment in the matter of Vivek Singh v. Romani Singh acknowledged the existence of PA. It also mentioned the psychological harm caused to the child and emphasized the importance of both parents' involvement in the child's life despite the marital conflicts. However, it did not discuss the role of mental health evaluation and intervention in the child-custody cases. In view of this paucity in the empirical understanding of its mental health implications, we present four case vignettes of children from separated/divorced Indian families to explain the distinct manifestations of PA and put forth clinical implications for practice.

Setting, Method, and Ethical Clearance

This study was part of the first author's doctoral research approved by the Institutional Ethics Committee. It utilized a case study method to describe the manifestation of PA in four children from separated/divorced Indian families in South India. Among the cases referred by the family court for mental health evaluation to a tertiary-care center between July 2017 and June 2018, four cases that

[1]Dept. of Psychiatric Social Work, NIMHANS, Bengaluru, Karnataka, India. [2]Dept. of Child and Adolescent Psychiatry, NIMHANS, Bengaluru, Karnataka, India.

HOW TO CITE THIS ARTICLE: Nambiar PP, Jangam KV and Seshadri SP. Parental Alienation: Case Series from India. *Indian J Psychol Med.* 2023;45(3):304–306.

Address for correspondence: Kavita V. Jangam, Dept. of Psychiatric Social Work, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka 560029, India.
E-mail: kavita.nimhans@gmail.com

Submitted: **22 Jan. 2022**
Accepted: **16 May. 2022**
Published Online: **01 Aug. 2022**

Copyright © The Author(s) 2022

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution- NonCommercial 4.0 License (http://www.creativecommons.org/licenses/by-nc/4.0/) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the Sage and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/02537176221104363

met the PA criteria were selected using purposive sampling. The authors retrospectively reviewed the case files, maintaining anonymity and confidentiality, and patients were not contacted for the study as only available medical records were utilized.

Case Series

Case 1 is of an eight-year-old girl. She resided with her mother and had no contact with her father in the past six months after parental separation. She was referred for mental health evaluation upon the father's court petition with regard to the child's refusal to talk to him. Upon inquiry, the child gave unfounded reasons for disliking her father, with statements like, "I don't like my father as he lets me sleep longer and does not wake me up at 6 am." She also used age-inappropriate phrases like "My father has a personality disorder; he first loves you, and then he devalues you."

Case 2 is of a nine-year-old girl. Since her parents separated three years ago, she has been residing with her mother and visiting her father on holidays. However, during her latest visit, after spending one month with her father, she vehemently refused to go back to her mother. In this context of custody arrangement violation, the court ordered a mental health evaluation of the child. During the interviews, the child didn't display any guilt about the lost relationship with her mother and said, "I don't care how my mother feels; I won't talk to her" and also generalized her hatred towards her grandparents and said, "She and her parents have always harassed me."

Case 3 is of a seven-year-old girl. Since her parents' divorce two years ago, she has been residing with her mother and refused to visit her father. However, her father attempted to enforce visitation by involving police personnel. In this context, the mother alleged that the child was traumatized by the coerced visitation and required mental health evaluation. In all sessions, it was observed that the child wanted the mother's presence and looked up to her before she said anything. The child denigrated the father and said, "He (father) always hit me and told me not to talk about it to anyone." She lacked any ambivalence in her preference for her mother and said, "I am very happy with my mother but very scared of XYZ (Referred to her father by his name)." Furthermore, she said, "I don't have a father," and added, "I just know it; nobody has asked me to say this," thereby affirming that it is her autonomous opinion.

Case 4 is of a 12-year-old boy. Since his parents divorced three years ago, he resided with his mother and visited his father on weekends. However, for the past seven months, the child has been getting more aggressive and hostile towards the mother and other members of the maternal household, including his younger sister. In this context, he was brought for mental health evaluation. In the mother–child sessions, the child said, "You are a bad mother; what have you done for me?" not showing any remorse about the overt hostility towards the mother. On the contrary, he showed reflexive support and indiscriminate approval of the father and said, "I will only be happy with my father; I love him." He furthermore generalized his hostility towards other family members and said, "My sister (4 years old) destroys my things; I hate her."

The mental health evaluation was done using qualitative detailed workup pro forma. Despite the context-specific interpersonal issues between the child and the alienated parent, in the first three cases, the children were not found to have any psychiatric issues and displayed adequate socio-occupational functioning. However, in case 4, the child, who exhibited defiance, anger, agitation, and spite impacting the child's socio-occupational functioning, was diagnosed with oppositional defiant disorder. This child was treated in inpatient care with a focus on individual therapy and parent management training for the behavioral issues. However, one of the major impediments in the treatment was the non-cooperation and non-involvement of the alienating parent, resulting in a poor prognosis.

Discussion

In all the above four cases, the verbatims of the children corresponded to Gardner's earlier-mentioned criteria for PA as highlighted in the western literature. The verbatims corresponded in Case 1 to PA characteristics of "Unfounded rationalization" and "Borrowed scenarios"; in Case 2 to "Absence of guilt" and "Generalization of animosity"; in Case 3 to "Campaign of denigration," "Dichotomy of parents," and "Independent-thinker"; and in Case 4 to "Automatic love" and "Generalization of animosity." It was also observed that in two cases, the alienator was the custodian mother. In the other two, it was the non-custodian father, thereby discounting any gender biases pertaining to the alienating parent.

Considering the above-mentioned characteristics, international experts in family law and child mental health agree that PA adversely impacts the child's mental health.[6] According to Baker,[2] the exploitation of the child by the alienator results in a long-term impact on the child's psychological development, including damaged self-esteem, shame, guilt, and insecure attachment from being rejected by the alienator for any positive interactions with the alienated parent and subsequent development of parental abandonment and trust issues in their adult relationships. Here, the interactional parent–child dynamic that underplays puts the child in a position wherein the child must choose between the parents, as the collusion with the alienator will result in the rejection of the other parent and does not permit the child to maintain a healthy relationship with both parents. Hence, we need to focus on these dysfunctional interaction patterns and categorize PA as a form of child abuse that results in emotional and attachment injuries and lost opportunities for developing a normal parent–child relationship, thereby increasing the risk of the child becoming the alienator in the future.[2,3] It is hence clear that a child's best interest lies in its identification and intervention rather than acceptance of the child's unreasonable parental preferences.

Therefore, the intervention can use the structural family therapy approach to conceptualize PA for restructuring parent–child interactions and behavioral sequences.[7] Also, since vengeance, insecurity, and jealousy against the ex-spouse are common contributing factors to PA,[8] couple therapy will also serve as a preventive mechanism to address PA and facilitate healthy separation and parenting. To accomplish these therapy

goals, MHPs must coordinate with the judicial system. The principles of behavioral science are embedded in family law. Hence, MHPs play a vital role in advocating for child-centric provisions in family law.[3] This can be achieved by liaison with and sensitizing the judicial system about the characteristics and impact of PA and other relevant constructs. This would, in turn, facilitate court-mandated therapeutic interventions with parents for cooperative and consistent parenting techniques to protect the child from loyalty conflicts and promote their mental health.

Due to the highly acrimonious nature of these custody cases, we must also be aware of the possible roadblocks. The therapists may encounter the refusal and non-cooperation of the alienators, thereby sabotaging the therapeutic progress. In such a case, it is imperative to recommend the court to transfer/terminate the child's custody/access.[9] Another major impediment in this area is the lack of its recognition, which could be because most child MHPs may view the child's rejection of the parent as stemming from abuse or neglect.

Despite the limited number of cases included, this study is a novel attempt to provide evidence on the characteristics of PA among children attending a tertiary-care center in South India. Describing this phenomenon is useful for MHPs to identify its manifestations in clinical settings, particularly in child custody cases. Hence, based on ICD classification, PA can be reported as a relational problem between the caregiver and child, as per code QE.52 in ICD-11.[10]

Conclusion

This study shows that PA is an unresearched grim reality in the Indian context. However, with increasing divorce rates and subsequent custody disputes in India, MHPs need to identify, notify, and intervene in cases of PA. These cases showed distinct PA characteristics that were independent of other post-divorce issues that influenced the child's mental health. Despite the debate and controversy regarding PA being a syndrome or not, we can certainly agree that it is a problem of dysfunctional family relationships wherein the child is triangulated between the "alienator" and "alienated" parents. It is thereby imperative to recognize that PA is not just a custody issue but an issue of child protection and child rights. Future research must hence focus on the systematic and empirical understanding of PA and the development of preventive and therapeutic frameworks to be incorporated within the Indian judicial system to safeguard the best interest and mental health of the children involved.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This study is a part of the first author's doctoral research approved by the Institutional Ethics Committee (Ref: NIMH/DO/IEC(BEH.Sc.DIV)/2018) and funded by the University Grants Commission (Ref: 1299/JUNE 2015).

ORCID iD

Kavita Jangam https://orcid.org/0000-0003-0481-6587

References

1. Dommaraju P. Divorce and separation in India. *Popul Dev Rev* 2016; 42(2): 195–223.
2. Baker AJ and Ben-Ami N. Adult recall of childhood psychological maltreatment in "Adult children of divorce": Prevalence and associations with concurrent measures of well-being. *J Divorce Remarriage* 2011 May 1; 52(4): 203–219.
3. Gottlieb LJ. *The parental alienation syndrome: A family therapy and collaborative systems approach to amelioration*. Charles C Thomas Publisher; 2012 Apr 1.
4. Gardner RA. The parental alienation syndrome, a guide for mental health and legal professionals. *Am J Fam Ther* 1992; 20: 276–277.
5. Gardner RA. Parental alienation syndrome vs. parental alienation: which diagnosis should evaluators use in child-custody disputes? *Am J Fam Ther* 2002 Mar 1; 30(2): 93–115.
6. King V. Parental divorce and interpersonal trust in adult offspring. *J Marriage Fam* 2002 Aug; 64(3): 642–656.
7. Kerig PK and Swanson JA. Ties that bind: Triangulation, boundary dissolution, and the effects of interparental conflict on child development. In: MS Schulz, MK Pruett, PK Kerig and RD Parke (Eds.) *Strengthening couple relationships for optimal child development: Lessons from research and intervention*. American Psychological Association; 2010, pp. 59–76.
8. Gardner RA. Family therapy of the moderate type of parental alienation syndrome. *Am J Fam Ther* 1999 Jul 1; 27(3): 195–212.
9. Mercer J. Are intensive parental alienation treatments effective and safe for children and adolescents? *J Child Custody* 2019 Jan 2; 16(1): 67–113.
10. Bernet W, von Boch-Galhau W, Baker AJ, and Morrison SL. Parental alienation, DSM-V, and ICD-11. *Am J Fam Ther* 2010 Mar 11; 38(2): 76–187.