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DSM, MENTAL HEALTH AND PARENTAL ALIENATION SYNDROME

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At present there is an intense debate over the so-called Parental Alienation Syndrome which, among other issues, focuses on the inclusion or exclusion of that syndrome in the DSM system. In this situation, a review and analysis of the very foundations of both the DSM and the concepts of "mental health" vs. "mental illness", lays the groundwork for a more adequate delimitation of the reality of the existence of the problem known as Parental Alienation Syndrome. Following this review and analysis, the authors propose a specific location for the conceptualization of PAS.
***Key words**: DSM; Parental Alienation Syndrome; Relational disorders; Mental Health*

En el momento actual se constata un intenso debate sobre el denominado Síndrome de Alineación Parental que, entre otras cuestiones, se centra en la inclusión o exclusión del citado Síndrome en el sistema DSM. En esta situación, una revisión y análisis de los fundamentos mismos tanto del DSM como de los conceptos de "salud mental" vs "enfermedad mental", sientan las bases para tratar de delimitar más adecuadamente la realidad de la existencia de la problemática conocida como Síndrome de Alineación Parental. Tras esta revisión y análisis, los autores proponen una ubicación concreta para la conceptualización del SAP.
***Palabras clave:** DSM; Síndrome de Alienación Parental; Trastornos de relación; Salud Mental*

WHAT THE DSM IS AND WHAT IT IS NOT

The DSM (Diagnostic and Statistical Manual of Mental Disorders) is a nosology; this means that it is a system of classification of diseases and disorders which primarily present mental and behavioral symptoms, although not exclusively (see, for instance, somatoform disorders), with independence of their etiology, most of them unknown. The DSM has, aside from other characteristics, a double sense; it is at the same time "the classification", that is, the list of accepted diseases included under certain categories and "the system" for diagnosing them, or what is the same, the diagnostic mechanics of such disorders, which in this case is done through diagnostic criteria and a multiaxial system.

The diagnostic criteria are basically the confirmation of the presence of behaviors and mental produce such as thoughts (deliria), personality traits (impulsivity), etc. It is based on the clinical detection of these phenomena in a descriptive manner and does not include etiological or etiopathogenic criteria simply because, beyond theories and models with more or less empirical or experimental basis, for most of the disorders included in the DSM, these are unknown. Furthermore, in some of those where a clear cerebral etiology is recognized, such as Alzheimer´s type dementias, the complete etiopathogenic processes are unknown.

The inclusion or not of a possible disorder and/or disease into the system, or its removal is carried out by a committee of experts who periodically makes revisions but not at fixed dates. This means that when a revision of the system or new edition is decided, committees of experts for the different categories are created who, after revising the scientific literature available in the period of time between two revisions, the different proposals made by institutions, and with the collaboration of the experts deemed necessary, make proposals which will or will not be accepted by the revision committee.

The organization, on which the DSM depends and, therefore becomes its endorser, is the APA (*American Psychiatric Association*), and hence, the DSM reflects, to a great extent, the thought and dominant positions in the APA at any given moment. This organization is not the only source of influence on the manual. Since its third version in the nineteen-eighties, increasingly more efforts are being made to coordinate with the ICD system, which is the diagnostic coding system of diseases proposed, endorsed and used by the WHO (World Health Organization) and whose Chapter V is dedicated to mental and behavioral disorders. As a result, there is a more or less explicit aim that sooner or later a sole nosology in mental disorders with unique codes for each

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disorder will be reached, under the APA (DSM) or WHO (ICD) umbrella or under both. We have not yet reached this point, although it seems that this is the purpose. It has not been clearly specified anywhere, but the truth is that on the DSM committees of experts there is an increasing influence of the NIMH (*National Institute of Mental Health*), which is the North American State Agency for Mental Health and which has perhaps become the official pressure group, non-private, and therefore, it does not exclude pharmaceutical laboratories, most important in the elaboration of guidelines for mental health and illness policies worldwide. This does not exclude the possible influence of these laboratories and other private institutions on the NIMH, which would redound in indirect influence in the DSM system.

Within this conglomerate of intertwined influences and interests, it seems that the WHO's ICD system is in tow of the DSM, that is, by that endorsed by the APA, and to a certain extent by the NIMH. This provokes a somewhat curious situation; the fact that finally and perhaps for the first time in the history of humanity, the beliefs about what mental illness is and what it is not is in the circumstance of availing of a certain unanimity at a world level, and this unanimity is literally oriented by a professional association in one country, perhaps helped as well by a state agency of that same country; all this, of course, under the umbrella of scientific knowledge. In essence, this is no more than one more expression of the globalization process.

The reasons for the success of the DSM are so evident that few people argue about them; essentially these can be summarized as commodity and peace of mind. In fact, after a long period of more than 23 centuries in which, from the dominant scientific perspective in the Western world, mental diseases were not distinguished from the rest of diseases, the dominant Hippocratic view until the 17th and 18th centuries, followed another period of great confusion in which, in the first place, the identification, individualization and clinical characterization of the different diseases and disorders which the collapse of the Hippocratic model made disappear, took place. Approximately in the middle/at the end of the XIX century, there was an attempt to describe the etiology and ethiopathogeny of mental diseases in terms of brain disease. This task soon proved to be enormous and impossible due to the lack of the necessary technology for this purpose, among other reasons; technology that we are still lacking despite the evident advances that have taken place in the neurosciences and other disciplines in this regard. In response to this evidence, a flood of models was produced. In fact, faced with the lack of a consensus regarding what a given disorder is, how it is individualized and how is it characterized, the mental illness field became fragmented into different models which offered different denominations, classifications and explanations for the same phenomenon, often clearly contradictory one from another. The paradigm which is most often used to refer to this phenomenon is that of the blind and the elephant; each blind person describes the elephant according to the part he/she touches.

By the middle of the 20th century, the situation had degenerated into such pandemonium that not only did it seem conceptually impossible or incredible, but also professionally and technically uncomfortable. It is best described with an example which has been reiteratively cited; there was almost two thirds more probability of being diagnosed with schizophrenia in the US versus Europe presenting the same clinical symptoms, given the different criteria used for the same denomination. This confusion was so inappropriate and uncomfortable that most people accepted with relief the attempt to unify into one nosology, which would provide a common language enabling us to communicate with each other. This not only facilitated clinical and forensic tasks, but also introduced a common factor in the selection of samples for investigation, a basic aspect which is never sufficiently praised and which ended the "wars" about models, at least in what referred to diagnosis; therapeutic approach is another question. To sum up, for commodity and peace of mind, although some think it is the peace of cemeteries.

These aspects are so valuable in themselves that not only does almost nobody question them, but also almost nobody desires to regress to the previous situation, nobody wants to return to the confusion. In some ways, we have turned the DSM into a sort of arbiter facing our disagreements although on a very primary level given the entity of our discords. This probably means that the tendency started by the DSM, and to a lesser extent the ICD, will not only not stop but will continue forward; we are all anxious to see the final result of the DSM V.

However, there are things that the DSM is not; it is not the sum of knowledge about mental illness in humans; by definition it only adopts the knowledge for which there is a certain consensus from a given perspective, that of the APA, implicitly accepted by most professionals and scientists, as we have seen. What we know about mental

disorders/diseases goes way beyond the DSM. Interventions and treatment by definition are excluded from the manual; clinical presentations, atypical cases and others which are not, clinical courses, more precise epidemiology, implicated factors of all kinds; cerebral, social, cultural, psychological, of personality, etc., etc., and naturally, a great number of syndromes, disorders, possible diseases, clinical situations which professionals are confronted with daily and are not included in the manual, or had been included and were "skipped" or are on "waiting lists" or any other possibility. Essentially, not only what the manual describes exists but what we see in daily practice exists. Things exist outside of the fact that they are named "officially". A good example of this would be Dostoyevsky´s case. To what point can we know that Dostoyevsky was a pathological gambler. Today, he would be a pathological gambler; at the time, by no means did any medical manual include this term or concept. It was unthinkable for a Russian or a European of the 19th century to consider this condition as something clinically pathological; it was something which pertained, in any case, to moral and/or religious spheres; morally sick or depraved. However, Dostoyevsky, in his novel "The Player", masterfully describes the clinical presentation of pathological gambling. In sum, Dostoyevsky was a pathological gambler although this problem was not recognized in his time as pathological gambling did exist in his time as it probably did in all others; it was distinguished and systematized when the historical moment and social context made it possible. We will return to this idea when we discuss the PAS.

Thus, the DSM is not the great compendium of all psychopathological and psychiatric knowledge pertaining to clinical psychology. It is what it is and those of us who appreciate its value and the contribution it has made and is making in this field of knowledge and to the practice of our profession, recognize it with a certain humility.

MENTAL DISEASE AND MENTAL HEALTH

Mental illness and mental health are not the same, and naturally, neither are they, contrary to what it may seem, two sides of the same coin.; one is not the opposite of the other; an individual cannot develop mental health if he/she has a mental illness given that every type of illness implies a certain degree of discomfort, but the lack of mental illness is not sufficient to achieve mental health. The WHO established this in their reiteratively mentioned principle that "health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (http://www.who.int/classifications/en/). This means that a person may not be ill and/or suffer from any mental disorder but that the person's physical, social or psychological conditions may not be those characteristic of mental health; they could simply be neutral or favor poor mental health which in the future could become a mental disorder. For example, a chronically battered woman in the domestic sphere neither has a mental disorder nor is mentally ill, but generally does not have a good mental health. Her social (familial), psychological and, sometimes, physical conditions are marked by suffering and, therefore, are not of wellbeing. Some of these women get to develop mental disorders, usually depression, anxiety and post-traumatic stress, and others do not. When they are finally able to leave the abuse behind is when their conditions improve in reference to improving their mental health.

The previous example is so clear that we could find hundreds of examples like it in any sphere of the lives of adult men and children; it could be extrapolated to the child bullied at school, to bad working conditions, to the use of inadequate coping strategies or to certain personality characteristics that although not pathological in themselves do not favor mental health. In all of these, mental illness does not necessarily have to be present, neither does there have to be poor mental health; the capacity for survival and resistance of human beings is enormous and this makes us very adaptive to our environment, so much so that it is possible we will destroy it. They simply do not help in the way of favoring mental health, that is, of favoring a state of wellbeing for the present and the future in the case of children.

We, as mental health professionals, are aware of this, and thus, although the first care that we always provide is the detection of mental illness and its intervention, we know that this will not be enough to achieve the complete well-being of our patients; it will often be necessary to make some changes in his/her environment, understood in a generic manner, and/or in his/her psychology, in order to make progress in the sense of an authentic state of well-being.

This is even truer in children where diagnosis and intervention are specially made with a projection to the future; we are concerned about the presence of disorders at the present moment and we are concerned about the circumstances which in the future could favor or harm their mental health and favor the apparition of mental disorders.

Forensic psychologists also know this when making their recommendations in court; they report not only about the present state of the child but also about his/her future. For this, they very frequently use the expressions "a correct psychosocial development is better guaranteed…" "the child's psychosocial development is protected better…"present and future psychosocial needs are better met if…".With this, a mental health situation is referred to, not mental illness.

From this perspective, the DSM is not a manual that deals with problems related to mental health but rather to illness and mental disorders and even with respect to these it moves in an environment of great ambiguity. This is reflected not only in the definition of mental disorder which is conceptualized as "*a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom), or disability (e.g., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom*" (APA, pp. XXI of the introduction to the Spanish edition, 1995)

As can be observed by the previous definition, the concept of mental disorder presents a high component of social consensus as it is not defined by the simple presence of symptoms or signs recognized in clinical exploration, but rather by its association to distress, disability or significant risk etc.; for example, by its capacity to make a person "lose his/her freedom". Who defines it? The clinician, the patient or the context? And if a deviation in behavior which does not produce distress, disability or significant risk appears…?

The summary is that the DSM system does not define mental health but mental illness and even then, with a great degree of inexactness. An indication of this is that it has great difficulty in encompassing the totality of the clinical cases that mental health professional attend (psychiatrists, psychologists, etc.) either because it does not recognize it in spite of its existence as in the cases of the Stockholm Syndrome, the battered wife syndrome or the anxious/depressive syndrome, or because it recognizes it but it barely fits this definition, as is the case of a great number of difficulties related to school learning, or because they represent a new clinical reality which is difficultly recognized.

A good example of this could be abuse in the familial context. Of course, not all women and children exposed to abuse in any of its forms will develop a mental disorder which is recognized and recognizable by the DSM. Not all victims present post-traumatic stress or depression as it is defined by the DSM; there is great variability in response because human beings are by definition very variable individually, but in every victim we observe suffering, pain, a certain victimization syndrome not described by the DSM, and of course, a severe risk situation for his/her present and future mental health which should be responded to promptly in order to preserve it and/or restore it, whether or not a disorder recognized by the DSM is observed.

Both mental health and mental illness are intimately linked to their social context, just as is reflected by the definition of disorder itself in the DSM system, in some ways, not in all, it is highly changeable as a function of the afore-mentioned context and the historical moment. The high variability of what has been understood as sexual disorders throughout the history of western thought and its association to specific circumstances (the impregnation of religion in civil life, etc.), is a good example of this. There is agreement that we are in a changing world: globalization, the information society, new ways of relating, changes in the family, etc.; inevitably this has to be manifested in the concept of psychopathology, mental health and mental illness. A good revision of these can be found in the text by A. Talarn (2007) "Globalization and Mental health". The main idea is that in a different society, with different realities and conditions, new forms of disorders and ways of getting ill will appear as well as new challenges regarding mental health which will have to be focused in a new manner. It is possible that the Parental Alienation Syndrome (Gardner, 1985, 1999, 2001, 2002a, 2002b, 2006) constitutes, together with an important number of disorders and clinical situations, a faithful reflection of this new reality; in this case in the world of the family, a changing reality which nobody disagrees with.

PAS and DSM

As previously mentioned, the DSM cannot encompass, by definition, the totality of the mental health conditions which human beings, understood in its just holistic sense, may be involved in. To the point that the system itself recognizes that it had to search for a trick, a subterfuge in order to save the situation; the trick is a category denominated "*other conditions that may be a focus of clinical attention*". The DSM covers in this section "*other*

conditions or problems that may be a focus of clinical attention and are related to the mental disorders described previously in this manual in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder ….”(APA, 1995 pp. 691, Spanish version). It can be observed how the definition revolves around the fact that the conditions are the focus of clinical attention, from which we inevitably come to the conclusion that these constitute real conflictive situations, not invented, where humans suffer and can and should be helped, although they do not constitute states of mental disorder.

Moreover, in this section there is a subsection denominated *“relational problems”*, which are defined as *“patterns of interaction between or among members of a relational unit are associated with clinically significant impairment in functioning, or symptoms among one or more members of the relational unit, or impairment in the relational unit itself. The following relational problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. These problems may exacerbate or complicate the management of a mental disorder or general medical condition in one or more members of the relational unit, may be a result of a mental disorder or a general medical condition, may be independent of other conditions that are present, or can occur in the absence of any other condition.”* (APA, 1995 pp. 696, Spanish version). It seems evident that from the descriptive perspective PAS includes a pattern of interaction of a relational unit (parents and children), which results in a clinically significant impairment in functioning (marked presence of psychological pain and risk in the psychosocial development of the minor given the complete absence of one of the parents) and it can appear related to a pathology in one or more of the unit members or in the absence of any other disorder. And, of course, they are subject to receiving clinical attention; thus, it does not seem that there is any clinician in the world that when confronted with a child who “does not want to see his/her parent, does not want to have any sort of relationship with him/her” will deal with it with a simple “that is not important, let him/her not see him/her; it will pass”. This simply does not happen. At least the clinician will be concerned enough to try and figure out what is happening and come up with some hypotheses with respect to this.

Finally, within the category *“relational problems”* we find *“Parent-child relational problems”* characterized by *“the focus of clinical attention is the pattern of interaction between parent and child (e.g., impaired communication, overprotection, inadequate discipline) that is associated with clinically significant impairment in individual or family functioning or the development of clinically significant symptoms in parent or child”* (APA, 1995 pp. 696, Spanish version). Once again, we believe that from a descriptive perspective PAS fits this category as there is an evident impairment in parent-child communication associated with the possible impairment in individual functioning and, without a doubt, impairment in family functioning and, once more, the development of clinically significant symptoms in parents and children.

It can be observed how the possible cause of the relational conflict is not mentioned anywhere in the criteria for this category; this is coherent with the philosophy of the DSM system itself which claims to be atheoretical and does not consider any etiological item as diagnostic criterion for any category of disease or disorder, which obviously would have been useless given the level of established knowledge that we have about them. From this, it can be deduced that this diagnostic category **is not the PAS**, The PAS can simply be included under its umbrella in case its assignment into a diagnostic category in the DSM were necessary. In fact, in this category all the conditions in which a parent-child conflict is present would be included under the conditions established by the system and which have been commented, regardless of their cause and origin; abuse and/or mistreatment on the part of the parent, generational problems, etc., and of course, boycotting the relationship by one of the parents.

In a recent paper, Baker (2007) proposed an idea which we find very interesting and that we incorporate; when we converse with adults who in their infancy/youth displayed attitudes and behaviors of rejection toward one parent related with the boycott by the other parent and with no other origin, we find individuals, who were minors at the time, who lived through a highly conflictive and very “judicialized” separation of their parents, but also we find minors who lived through the separation of their parents with hardly any conflict, because the rejected parent renounced “putting up a fight” or simply “withdrew” and, most curious of all, we also find minors who report this experience in intact families who did not go through the process of separation and in fact, who always remained together. That is, in the context of intact families, a series of attitudes and behaviors on the part of a family member

(a father for example) can also be found with the tendency to run down, to deprive of authority, to hinder affects, etc., in essence, to boycott the relationship of the child with another member of the family (the other parent for example), with a negative effect on the psychosocial development and emotional health of the child and of course the family well-being.

In our opinion, this finding is important because it can lower the ideological tension in the discussion surrounding the PAS if it is not exclusively confined to the judicial field. In other words, the following question could be posed; is there enough basis so as to consider the existence of a family-relational pathology and/or a pathological pattern of familial communication, which can be present in any family context or situation, and is characterized by the presence of an attitude/behavior of rejection in children toward a family member, which is clearly related to attitudes/behaviors of boycott on the part of other family members, when other possible causal factors have been excluded?

Our proposal would be to consider the presence of a syndrome which goes beyond what is strictly clinical and legal and that possesses these characteristics, whatever it is called, not necessarily Parental Alienation Syndrome. This would be coherent as well with the proposal by Kupfer, First and Regier (2004), who in their paper regarding the research agenda for the development of the DSM-V raised the possibility of including a group of "relational disorders" at the same level as personality disorders which would include conditions where the core of the pathology would be the relational dynamics, with an evident association to the psychopathological consequences for the individuals trapped in such a relationship. Precisely, they gave as an example the case of "continuous spousal abuse".

If the answer to the question is affirmative, then there is a need to conduct research regarding this phenomenon in the multiple areas which make up mental health, epidemiology, the contexts where it is present, related social factors, related personality factors, intervention possibilities, etc. and always with the coldness and emotional distance which should characterize the scientist.

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