Stalking of the Mental Health Professional: Reducing Risk and Managing Stalking Behavior From Patients

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Stalking Defined

- ***"Willful, malicious and repeated following and harassing of another that threatens his or her safety"***

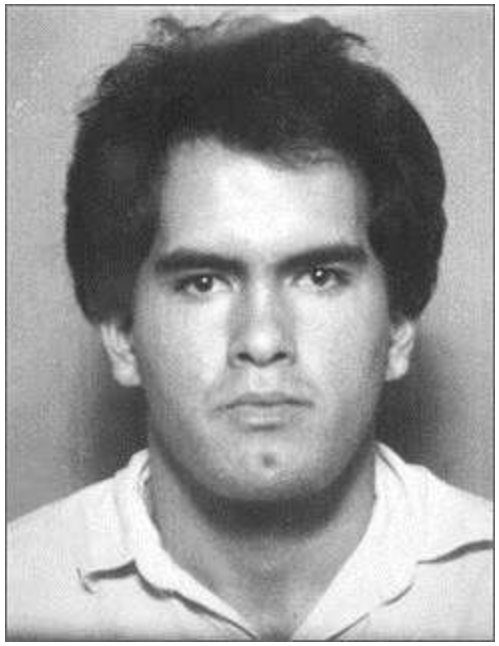
  -- ***Meloy & Gothard***

- ***"A course of conduct directed at a specific person that would cause a reasonable person fear."***

  — ***US Department of Justice***

Stalking Defined

An old behavior, a new crime *(Meloy, 2006)*



Stalking Behaviors

- Unwanted telephone & e mail
- Disclosure of victim's personal information
- Following the victim
- Visiting victim at work
- Loitering outside of victim's home
- Sending victim photos of victim
- Monitoring phone and computer use
- Computer research on victim
- Assault
- ***Watching*** the victim

Stalking Behaviors

- Violation of Protection Orders
- Sexual assault
- Vandalizing property of victim
- Burglary and theft
- Verbal or written threats
- Secondary Victims
- Killing victim's pets
- Sending or leaving unwanted cards & gifts
- Spurious legal action against victim
- Spreading malicious rumors about victim

Stalking Behaviors: Threats

- **Threats are common in most types of stalking**
- **Threats, alone, are a form of violence**
- **While most stalkers will not act on threats, violence is higher than in other threatening situations.**
- **Threats may increase, decrease, or have no relationship to subsequent violence**

Stalking Behaviors: Threats

- **Face-to-face threats are more serious than phone or mailed threats.**
- **The more specific the threat, the higher the risk.**
- **Signed threats are more dangerous than anonymous threats.**
- **Threats made in heat of anger less dangerous than threats late in the game after many efforts have been made to resolve the situation.**

Meloy, R.(1998)

The Modal Stalker

- Male in his 40s, pursuing a prior sexual partner
- Average episode ~2 years
- Most reoffend
- Have history of bonding failure
- Un- or under-employed
- 12-22% are female
- 40% of female stalkers (17% of male)
  - Stalk a prior professional relationship
  - Most commonly a family physician, psychiatrist, or psychologist.

Types of Stalkers

1. Rejected
1. Intimacy Seekers
1. Incompetent
1. Resentful
1. Predatory

Mullen & Pathe', 1999

Types of Stalkers: *Rejected*

"If you won't love me, then I will settle for your hating me."

Mullen & Pathe', 1999

Types of Stalkers: *Rejected*

-Approx 1/3 or all stalkers

-Narcissism, dependency, & suspiciousness common, but Axis I Dx uncommon

-Physical violence against victims or proxies over 50%!

-These stalkers do respond to threats of prosecution.

Mullen & Pathe', 1999

Types of Stalkers: *Intimacy Seekers*

"Madonna and I are meant to be together."

Mullen & Pathe', 1999

Types of Stalkers: *Intimacy Seekers*

-Approx 20% of stalkers.

-Pursuers of the rich and famous. Usually no history of a relationship in reality.

-Very persistent & not likely to respond to orders of protection or other threats of arrest.

-Often psychotic, including a significant subgroup with erotomanic delusions.

-Infrequently violent, but when it does occur, violence can be extreme.

Types of Stalkers: *Incompetent*

"Thanks for agreeing to have coffee with me. Would you marry me & bear my children?"

Mullen & Pathe', 1999

Types of Stalkers: *Incompetent*

-Quite common but frequency less certain because typically underreported.

-Not generally psychotic, but sometimes intellectually deficient.

-Socially incompetent & insensitive

-Approx 25% will be violent

-Do respond to police "knock & talk." But often move on to find new targets.

Types of Stalkers: *Resentful*

"If I must suffer, then so must you."

Mullen & Pathe', 1999

Types of Stalkers: *Resentful*

-Relatively uncommon.

-Half lack any real connection to the victim (symbol?)

-Typically not psychotic but strong feelings of self-righteousness and entitlement.

-Can be deterred with threat of arrest.

-Least likely to become violent – however . . . .

Types of Stalkers: *Predatory*

Sexual gratification/domination

Mullen & Pathe', 1999

Types of Stalkers: *Predatory*

-The least common.

-Hx of sexual offenses, with most having diagnosable paraphilias and psychopathy.

-Typically do not threaten prior to an attack.

-Attacks are common although the stalking itself may be a source of sexual gratification.

-Or, the stalking may be a prelude to the attack, which is the gratification.

Examples of Communications

THE BOTTOM LINE…

…after you scrape off all the fluff, the iphones, the clothe, status, possessions, cars, etc. we are all connected by the basic fact –we want to be loved, valued, acknowledged. Unfortunately the world does not support that value system..you can try and fill your emptiness with drugs, possessions—you fill in the blanks --- but you will still be empty.

Stalking in Health Care

- Underreported and underdiscussed in healthcare
  - 16% of women, 5% of men overall
- Who gets stalked the most
  - Psychiatry, OB, & Surgery
  - 6-11% of therapists are stalked (lifetime)
  - Younger therapists more vulnerable
- 10% of supervisees stalked

Stalking: Therapists

- Clinicians most commonly encounter
  - Incompetent: misinterpret empathy as romantic interest
    - Therapeutic relationship as a “relationship”
  - Resentful: possess some grievance.
    - Usually when they perceive rejection

Impact of Stalking

- 20-30% of victims seek counseling
- 1 in 7 move their residence
- 25% lose time from work
- 3% of therapist carry a weapon
- 8% change their profession
- 5% leave mental health altogether

Organizational Response to Stalking

- Most lack well-defined procedures
- Clinicians have minimal training
  - Training often unintentionally iatrogenic
- No definition of when patient confidentiality may be broken
  - Significant consequences if done inappropriately

Unique Challenges Posed by Mental Health

- When to break confidentiality
- Emphasis on avoiding harm/containing behavior
- Misinterpretation of stalking behaviors as benign clinical behavior.
- Stalking behaviors are covert
- Clinical vs. Criminal behaviors
- “Do no harm”
- Early behaviors highlighted as important to determine

The Case Of “Lisa”

“Lisa”

- “Tom” was a 55 yo married male patient, receiving hospital-based outpatient treatment for chronic pain and depression.
- “Lisa” was an experienced and well-respected outpatient psychologist.
- Tom initially responded well to treatment.
- Started requesting a hug and calling Lisa a nickname.
- Lisa tolerated because she believed therapeutic relationship would be enhanced.

“Lisa”

- Began bringing gifts for “the clinic staff.”
- Walking in park during therapy.
- Asked to take photos of the flowers in the park
  - (Took photos of her instead)
- Photo album presented.
- Therapist began to be more concerned & stated that she could accept no further gifts or photos for “other patients or clinic staff.”
- Said he would make an animated movie for her.

“Lisa”

- Presented animated film
  - “for your partner”
- Discussed with supervisor
  - Suggested she terminate
- Tom presented “short story”
  - To kill partner
  - Move in with her to provide “comfort & solace”
  - After 2 years as not to violate any ethical code
- Decision made with supervisor and admin
  - Transfer pt to male provider
  - Supervisor to meet with pt

“Lisa”

- Supervisor met with Tom
- Tom stormed out
- Sent a long letter to hospital administration
  - Detailing perceived maleficence
  - Newspaper clippings, poetry, photographs
  - Angry that he could not see a female provider

“Lisa”

- Lisa asked by managed care administration for a response to pt’s allegations.
- Tom came to MH appt with a video camera, filming in waiting room
- Eventually had care paid for in the community by the managed care organization.
- Review of records
  - No clear signs
  - No criminal history
  - One note of past sexual relationship and obsessional thoughts about a primary care employee

“Lisa”

- Lisa: distress, problems with concentration, sleep, intimacy, relationships with coworkers
- “bleeding out at work,” told to not talk because it was “juicy.”
- Alienated and felt her competence was in question.
- Previously social, no longer.

“Lisa”

- Lisa: sought consultation from an outside attorney
  - Felt real world solutions, normalization, validation
- Tightened her boundaries
- Altered informed consent
  - Written, detailing inappropriate behaviors
- Stopped hugging, no therapy outside the office walls

“Lisa”

- Continues to fear Tom
- Ongoing questioning of decision-making
- Saw his behaviors as characterological, not as stalking
- Insidiously progressed
- Unconditional positive regard as reinforcing

A Management Model

- Acknowledge the potential for reflexive, "cookie-cutter" approach

- Preliminary Two-Tiered Model:

  Individual & Systemic
  - Primary
  - Secondary
  - Tertiary Prevention

Primary Strategies

- Initiated prior to stalking and globally applied to all clients and to the system

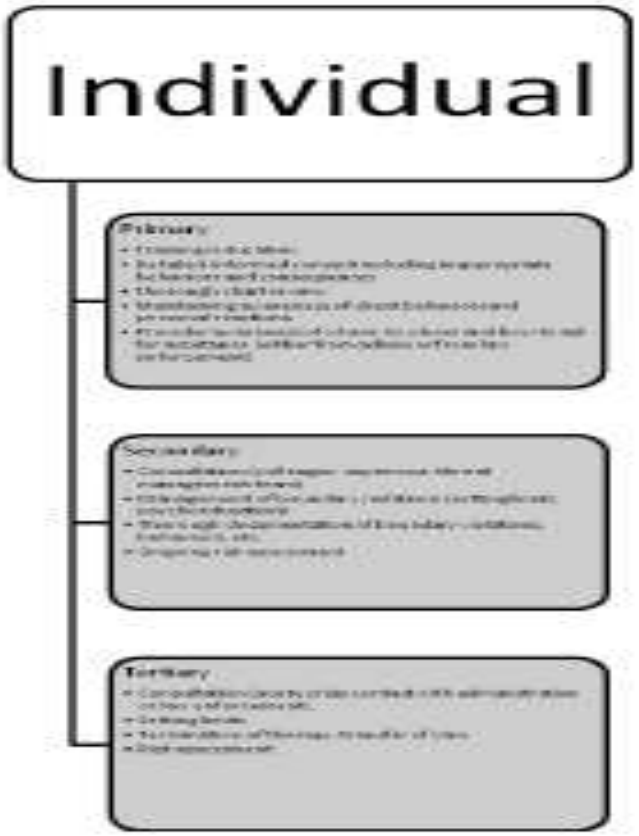
Secondary Strategies

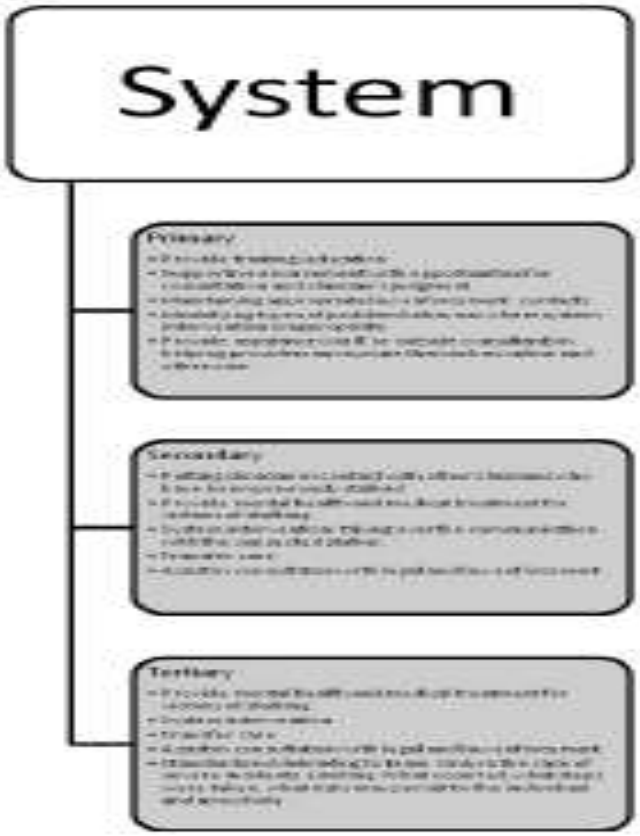
- Necessary when 2 conditions are met:
  - A client begins to test or violate boundaries and expected behaviors agreed upon during informed consent
  - The clinician begins to have concern, discomfort and/or fear about their client's behavior

Tertiary Strategies

- Are to be used if the client's stalking behaviors are sufficient enough to cause harm or threat of harm to the clinician's emotional or physical safety.

The Model


Individual
Primary
Secondary
Tertiary


System
Primary
Secondary
Tertiary

Individual Interventions

- Primary Prevention:
  - Education on which behaviors constitute stalking bx, general violence risk factors, and suggested appropriate responses.
  - Detailed informed consent
  - Chart review and consultation
  - Maintain awareness of potentially inappropriate behaviors, early communication/reiteration of boundaries
  - Provider awareness of where, to whom, and how to request assistance.

Individual Interventions

- Secondary Prevention:
  - Initiating further consultation
  - Informal social support from colleagues
  - Directive support and response from supervisors
  - Setting limits and addressing boundary violations
  - Documentation in record of violations
    - Method of doing so needs to be determined with supervisors and legal counsel.

Individual Interventions

- Tertiary Prevention:
  - Initiate an acute crisis contact with administration or law enforcement
  - Setting of limits: clear, direct and absent of vagaries
  - When a clinician feels threatened, the relationship is over
  - Care of patient transferred to supervisor and administration
  - Communication severed between pt and provider

Individual Interventions

- Tertiary Prevention (ctn):
  - Notice sent to patient that all communication should go through the supervisor
  - Documentation and communication to the threat team and administration
  - Any contact should be met with the same notice detailing conditions of communication
  - Referral to another provider should be made thoughtfully

Systemic Interventions

- Primary Prevention
  - Provide all clinicians with ongoing training in the prevalence of stalking, types of stalking behavior.
  - Make providers aware of how the system will support the clinician with a range of problematic client behavior.
  - Ways to seek help when the clinician is stalked
  - Practical suggestions to increase safety
  - Supervisor orientation
  - Maintain pathway to consultation
  - Maintain law enforcement contacts (esp. DV officers).

Systemic Interventions

- Secondary Prevention
  - Access a variety of consultants
  - Willing to have direct conversations with the stalker
  - Assist clients in transfer, or monitored maintenance of care
  - Assist clinician in obtaining resources for personal support
  - May consider putting clinician in contact with previously stalked clinicians
  - Provide leave of absence or other accommodations to reduce stress and risk

Systemic Interventions

- Tertiary Prevention
  - Provide support related to the effects of stalking
  - Intervene, with or without the clinician's presence
  - Transfer within clinic or to an external provider
  - Link clinician to legal practitioners and law enforcement
  - Ongoing follow up and monitoring of provider and patient

Systemic Interventions

- Tertiary Prevention

1. Debrief between admin, law enforcement, threat team
   - Determine ongoing management needs.

2. Provide debriefing to MH team
   - Limited to general indication of what occurred.
   - Administrative response.
   - What risks persist for the individual clinician and staff?
   - What is needed from staff?

Central Dilemma Revisited

- Dual role
  - Provider and victim
- Surreptitious behaviors
- Counter to training
  - Centrality of the therapeutic relationship
- Torn between professional obligations and personal safety.

Limitations

- Directed at institutional providers, assumes resources
- Based in research but untested as a real time model
- How to best use and harness social support
- Challenges posed by differing organizations

References

- Abrams, K. M., & Robinson, G. E. (2011). Stalking by patients: Doctors' experiences in a Canadian urban area. *Journal of Nervous and Mental Disease, 199*(10), 738-743.
- American Medical Association. (2009). *Code of medical ethics.* Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page
- American Nursing Association. (2010). *Code of ethics.* Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses.aspx
- American Psychological Association. (2010). *American Psychological Association ethical principles of psychologists and code of conduct.* Retrieved from http://www.apa.org/ethics/code/index.aspx
- Baum, K., Catalano. S., Rand, M., & Rose, K. (2009). *Stalking victimization in the United States* (NCJ 224527). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., … , & Stevens, M.R. (2011). *The national intimate partner and sexual violence survey: 2010 summary report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Bureau of Labor Statistics. (2010). Occupational Outlook Handbook. Retrieved October 7, 2012 from http://www.bls.gov/oco/ocos056.htm.
- Dinkelmeyer, A. & Johnson, M. B. (2002). Stalking and harassment of psychotherapists. *American Journal of Forensic Psychology*, *20*(4), 5-20
- Galeazzi, G. M., Elkins, K., & Curci, P. (2005). The stalking of mental health professionals by patients. *Psychiatric Services*, *56*(2), 137-138.
- Henderson, A. D. (2003). Nurses and workplace violence: Nurses' experiences of verbal
- and physical abuse at work. *Nursing Leadership*, *16*(4), 82-98.
- Lion, J. R. & Herschler, J. A. . (1998). The stalking of clinicians by their patients. In J. Reid Meloy (Ed). *The psychology of stalking: Clinical and forensic perspectives* (pp. 163-173). San Diego, CA: Academic Press.
- McIvor, R. J. & Petch, E. (2006). Stalking of mental health professionals: An underrecognised problem. *British Journal of Psychiatry*, *188*(5) 403-404.
- Meloy, J. R. (1997). The clinical management of stalking: "Someone is watching over me." *American Journal of Psychotherapy, 51*, 174-184.
- Meloy J. R. (2002). Commentary: Stalking, threatening, and harassing behavior by patients – the risk management response. *Journal of American Psychiatry Law, 30*(2), 230-231.

References

- Meloy, J. R., Rivers, L., Siegel, L., Gothard, S., Naimark, D., & Nicolini, J. R. (2000). A replication study of obsessional followers and offenders with mental disorders. *Journal of Forensic Sciences, 45*(1), 147-152.
- Mullen, P. E., Pathé, M., & Purcell, R. (2008). *Stalkers and their victims (2nd ed.).* Cambridge, UK: Cambridge University Press.
- Mullen, P. E., Pathé, M., Purcell, R, & Stuart, G. (1999). Study of stalkers. *American Journal of Psychiatry, 156*(8), 1244-1249.
- National Center for Victims of Crime. (2009). *Stalking safety planning.* Retrieved from http://www.ncvc.org/src/main.aspx?dbID=DB_Safety_Plan_GuideLines333
- Pope, K. & Vasquez, M. (2011). *Ethics in psychotherapy and counseling: A practical guide* (4th edition). Hoboken, NJ: John Wiley & Sons, Inc.
- Purcell, R., Pathé, M., & Mullen, P. E. (2001). A study of women who stalk. *American Journal of Psychiatry, 158*(12), 2056-2060.
- Romans, J. S. C., Hays, J. R., & White, T. K. (1996). Stalking and related behaviors experienced by counseling center staff members from current or former clients. *Professional Psychology: Research and Practice, 27*(6), 595-599.
- Rosenfeld, B. (2003). Recidivism in stalking and obsessional harassment. *Law and Human Behavior, 27*(3), 251-265.
- Sandberg, D. A., McNeil, D. E., & Binder, R. L. (2002). Stalking, threatening, and harassing behavior by psychiatric patients toward clinicians. *Journal of American Psychiatry Law, 30*(2), 221-229.
- Schwartz, T. & Park, T. (1999). Assaults by patients on psychiatric residents: A survey and training recommendations. *Psychiatric Services, 50(3)*, 381-383.
- StalkInc. (2011). *General advice for victims.* Retrieved from http://www.stalkingriskprofile.com/victim-support/general-advice-for-victimsTjaden, P. & Thoennes, N. (1998). *Stalking in America: Findings from the National Violence Against Women Survey.* National Institute of Justice, Centers for Disease Control and Prevention.

Questions?

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