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.

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
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
“Madonna and I are meant to be together.”
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 erotomaniac delusions.

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

Mullen & Pathe', 1999
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
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 therapists 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”
“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 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
- Cultivating the talents
- To develop informal concepts including teamwork
- To build and consolidate
- To achieve the goals
- To maintain records of the individual and produce

Secondary
- Communication (oral, written, non-verbal)
- Development of work-related
- Skills for the future
- Effective performance
- Support and assistance

Tertiary
- Communication (oral, written, non-verbal)
- Development of work-related
- Skills for the future
- Support and assistance
- Communication (oral, written, non-verbal)
- Development of work-related
- Skills for the future
- Support and assistance

System

Primary
- Information flow
- Communication channels
- Decision-making processes
- Analysis of data
- Identification of issues
- Improvement of performance

Secondary
- Communication (oral, written, non-verbal)
- Development of work-related
- Skills for the future
- Support and assistance

Tertiary
- Communication (oral, written, non-verbal)
- Development of work-related
- Skills for the future
- Support and assistance
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).
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


Questions?

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