

Commentary: Stalking by Patients—Psychiatrists’ Tales of Anger, Lust and Ignorance

Michele T. Pathé, MD, and J. Reid Meloy, PhD

Stalking is a thriving social and criminal concern and a risk inherent in our personal and professional lives. Health care professionals, particularly psychiatrists and other mental health practitioners, are vulnerable to being stalked by their patients and, far from providing helpful insights that discourage the behavior, their training can be a hindrance. Neither a psychiatrist’s gender nor seniority confers protection from the protracted vengeance or infatuation of a patient-turned-stalker, any more than does working through the transference and soldiering on. The ensuing social, psychological, and vocational damage can, however, be minimized through early recognition, informed advice, and the support, not censure, of our colleagues.

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Being stalked is an all too common experience. Between 17 and 30 percent of women and 4 and 12 percent of men in Western nations report being stalked at some time in their lives, the estimates varying according to the methodology and definitions employed.^{1–3} There is evidence that the incidence of these behaviors is increasing,¹ which may be related to greater instability in intimate relationships, increased social complexity and isolation, our contemporary culture of complaint, and the technologies that compromise our privacy.⁴ Stalking refers to the repeated infliction on another of unwanted communications (e.g., through letters, telephone calls, e-mail, and social networking websites), unwanted contacts (e.g., following and approaching), and a myriad of other harassing behaviors (e.g., malicious complaints, threats, and assaults), in a manner that causes reasonable fear and distress.³ Stalking behaviors can be divided into brief intense periods of harassment and episodes that persist beyond two weeks. The brief intrusions, though unsettling, are more commonplace and innocuous, but episodes that ex-

tend beyond two weeks appear to be more ominous, as they are likely to persist for months and are more damaging to the victim.⁵

Some occupational groups have a greater vulnerability to being stalked, including public figures^{6–11} and health care professionals, particularly in the mental health sector.^{12–32} There is a burgeoning literature in relation to public figure fixation and stalking, but we are only beginning to appreciate the nature and extent of problems experienced by other high-risk groups. In their article, Maclean and colleagues³³ have made a further valuable contribution to our understanding of the problem within our own profession and how we are dealing with it.

Patients who stalk health care practitioners are not a new challenge, and numerous studies have highlighted the frequency of threats, violence, and sexual harassment experienced by clinicians.^{15,23,34–45} Case reports of patients stalking psychiatrists^{46–48} underscored the vulnerability of our profession to the abnormal attachments of patients and the distress and disturbance this causes. In a case series compiled by Lion and Herschler,¹⁵ comprising a psychologist, a plastic surgeon, and seven psychiatrists, one of the health professionals ultimately strangled the patient who stalked him.

Studies derived from convenience samples of mental health practitioners^{13,14,17,22–26} have delivered further sobering insights. Among clinicians sur-

Dr. Pathé is Senior Forensic Psychiatrist, Queensland Forensic Mental Health, Service, and Adjunct Professor, Griffith University, Brisbane, Queensland, Australia. Dr. Meloy is Forensic Psychologist and Clinical Professor of Psychiatry, University of California, San Diego, School of Medicine, San Diego, CA. Address correspondence to: J. Reid Meloy, PhD, P.O. Box 90699, San Diego, CA 92109. E-mail: reidmeloy@gmail.com.

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veyed in one U.S. inpatient psychiatric facility, more than half the 62 respondents reported experiencing threatening, harassing, and stalking behaviors during their careers¹⁷; more than 20 percent of the 198 psychiatrist respondents sampled in a large U.K. mental health organization had been stalked by their patients²² for up to 16 years. These studies have consistently demonstrated the vulnerability of health care workers to stalking by their patients and the detrimental impact of these experiences on the victims' well-being.

Studies based on random samples of large populations of health professionals have revealed more detailed information, but their generalizability is hindered by low response rates, reliance on victims' reports, and inconsistent thresholds for stalking. For example, some studies employed a strict operational definition of stalking,^{21,31,49} whereas others used less rigorous, legally based criteria.³⁰ A large-scale survey by Whyte et al.³¹ included stalking in the subject's personal life and stalking by colleagues, and most random studies included stalking by the patient's partner or relatives.^{21,30,31} These studies have been conducted on samples of psychiatrists, other medical practitioners, psychologists, nurses and social workers, and heterogeneous samples of mental health workers.^{18,20,21,27,30,31} The career prevalence of stalking by patients in these samples ranged from 4 percent to almost 20 percent.^{20,21,29} The highest victimization rates have been recorded in the mental health professions, especially among psychologists and psychiatrists, and those involved in direct patient care. Prevalence in the surgical specialties approaches that of psychiatrists.^{27,30} Certain mental health and medical subspecialties may be less vulnerable by virtue of their patient profiles, or their limited patient contact (e.g., neuropsychology and organizational psychology,²¹ psychogeriatrics,³¹ nuclear medicine, pediatrics, emergency medicine, and internal medicine.³⁰) Stalking by the patient's relatives has been reported in over 10 percent of cases.²¹ The duration of stalking in these studies ranged from two weeks to more than 10 years.^{21,30} For over half the psychiatrists reported by Whyte et al.,³¹ stalking persisted for more than a year.

In these studies, the predominant motives for stalking reported by health professionals were anger or resentment and infatuation.^{21,26,30,31} Whereas Abrams et al.,³⁰ in a random survey of Canadian physicians, found no particular relationship between

stalking motive and specialty, in a survey of Australian psychologists,²¹ all clients who stalked forensic psychologists were resentful, while 42 percent of clients who pursued clinical psychologists were thought to have amorous motives. The psychiatrists described by Whyte et al.³¹ reported similar proportions of resentful and amorous motives. The main forms of harassment reported by health practitioners across all studies were repeated telephone calls, unwanted approaches, loitering, correspondence and e-mail, property damage, and unsolicited gifts.^{18,21,26,30,31} More than a third of health professionals surveyed in some studies were subject to threats to harm them or other parties, including family members. Physical and sexual assaults were not rare.^{21,30,31} These studies also show that vexatious complaints, including malicious reports to professional registration boards and regulatory bodies, are more likely to be experienced by health care practitioners than the wider community.^{21,31}

In one case, a psychiatrist's secretary, following his rebuff of her amorous attentions and termination, stole the psychiatrist's identity and began sending derogatory and threatening e-mails to his colleagues and other physicians he knew. She also sent e-mails to her own accounts under his name to stage a case of stalking. The case escalated to the point of criminal charges being contemplated against him and the licensing board in his state requiring a psychiatric examination of him to continue practicing. Both law enforcement and other regulatory professionals refused to believe that his secretary had the technical proficiency to do these things. She did. Eventually through a detailed Internet and computer forensic investigation, she was identified as the perpetrator and was arrested and criminally charged.

There are no specific traits, however, that would differentiate potential stalkers from other patients in the extant research. The perpetrators in these studies were more likely to be single, unemployed outpatients with a diagnosis of psychosis or personality disorder. Female stalkers were over-represented relative to stalkers in the general population.⁵⁰⁻⁵⁴ Typically, the victims were relatively experienced clinicians, and, again in contrast to the general population, male and female health professionals shared a similar risk of victimization by patients. While Purcell and colleagues²¹ found that on average stalking commenced within six months of establishing the professional relationship, the length of treat-

ment before the onset of stalking varied widely. Some eight percent of psychologists in their survey reported protracted stalking after the first therapeutic contact.

Most studies of stalking and harassment in health care workers have focused on mental health populations, both public and private, inpatient and outpatient in civil and forensic settings. This research correctly assumes that psychiatrists and other mental health professionals are particularly vulnerable to the unwanted intrusions of their patients. This exposure is not surprising, given the nature of the therapeutic relationship and our greater likelihood than other disciplines, and indeed most of the general population, of encountering seriously mentally disordered and unstable individuals with a greater propensity to engage in this behavior. The evidence suggests that one of the commonest motivations for a patient-turned-stalker is intense infatuation. Typically, a lonely and disordered patient misinterprets the therapist's sympathy and attention as romantic love. Such stalkers are categorized as intimacy seekers in the motivational typology of Mullen et al.^{55,56} In other patients, stalking and threats arise in the context of a perceived injury or injustice perpetrated by their therapists or the wider organization (commonly, an unfavorable report or compulsory treatment). These resentful stalkers^{55,56} may also be over-represented in the stalkers of our surgical colleagues. Therapists are also peculiarly susceptible to rejected stalking patterns. These more typically occur in the context of the breakdown of a sexually intimate relationship, but can arise from the termination of a (usually) long-term therapeutic relationship.^{16,56} Patients turned stalkers may simply be in some cases socially inept or intellectually disabled individuals who pursue their therapist for relatively short periods in the unrealistic pursuit of a date or friendship (incompetent suitors).^{55,56}

Unfortunately, the stalking of mental health professionals by their patients tends to be characterized by protracted periods of intrusive behavior lasting months or years, rather than brief bursts of harassment. More extended episodes are associated with patients who are deluded and female,^{21,30} again not a unique group in psychiatric practice. Anger in relation to perceived mistreatment has been found in some samples to generate more transient bouts of intense harassment,³⁰ but resentful stalkers can be quite persistent.⁵⁷ The more protracted stalking pat-

terns observed in populations of health professional victims is of concern, given that the most robust predictor of stalking morbidity is the duration of the stalking episode.⁵⁸

There has been a stronger emphasis in the literature to date on the social and physical impact of stalking on mental health professionals, perhaps reflecting the reluctance of our colleagues to acknowledge psychological distress and impairment in research of this type, or, as Sandberg and colleagues¹⁴ suggest, "denial and minimization are common reactions to being the target of patients' aggressive behavior" (Ref. 14, p 1103). We do know that stalking is a destructive behavior with the potential to devastate the professional and personal lives of mental health practitioners, the patient-turned-stalker, and other parties. These studies have highlighted the anxiety, depression, anger, helplessness, guilt, and self-doubt experienced by the victims, as well as disillusionment with their profession.^{16,21,28,31} They report maladaptive coping mechanisms such as alcohol, tobacco, and other substance abuse.^{31,59} Many have felt compelled to modify their lifestyles, including moving their home and bolstering security. Practice changes are frequently reported, such as altering one's treatment style, referral restrictions, security upgrades, and practice relocation. The impact of malicious complaints to professional registration boards and other agents of accountability can be particularly harmful, as these complaints tend to be taken at face value, and the status given to such allegations can reward and reinforce the stalker's efforts. For the stalked health professional, the complaint process can be experienced as a further form of harassment.^{28,59} Indeed, it has been found that stalked clinicians who experience vexatious complaints are more likely to contemplate or actually leave their professions.²¹ Random studies probably underestimate the proportion who ultimately abandon their careers as a consequence of stalking, as these samples are drawn from professional registers of current members.^{21,31}

In studies of stalked health professionals, most victims sought advice and assistance from several sources, with various outcomes. Whereas some respondents found these avenues helpful,^{13,17,21,24,25,31,33} others described a litany of abuses, including implied or overt criticism from other professionals, dismissive attitudes from law enforcement, and skepticism from supervisors, em-

ployers, and professional organizations.^{16,29,31,33} The lack of assertive police intervention may relate to a general reluctance to prosecute the mentally ill⁶⁰ or a tendency to view stalking in the context of prior relationships as somehow of less concern. It could also reflect a wider view that this is par for the course in mental health circles and that we have the skills to deal with it.

In their illuminating article, Maclean et al³³ provide a more detailed analysis of the experiences of a large sample of U.K. psychiatrists. This study is derived from an earlier questionnaire survey of members of the U.K. Royal College of Psychiatrists. The survey was hindered by a low response rate (under 25%), but 11 percent of the 2,585 respondents reported experiencing harassing behavior that met stringent research criteria for stalking.¹ The stalker was a patient in 64 percent of these cases.³¹ The subsequent thematic analysis³³ provides further support for the negative emotional impact of these experiences on psychiatrists. This study also demonstrates persisting uncertainty in our own profession as to what constitutes stalking and the tendency of some psychiatrists and other agencies to assume it is an acceptable part of the job. Some psychiatrists may not have experienced the requisite fear included in the operational definition of stalking because their prior knowledge of, and perhaps sympathy for, their patient-turned-stalker fostered a false sense of security.²⁸ In this qualitative analysis, the level of professional support received had a mitigating effect on harmful impacts. Constructive advice and support were not readily forthcoming, however, as the individuals and agencies they approached shared similar prejudices (particularly, that psychiatrists should expect such intrusions). Stalking victims in general are unreasonably inclined to blame themselves for their predicament, and this is commonly reinforced by the ignorant or insensitive responses of those whom they approach for help. They blame themselves for their choice of partner, for their unassertiveness, for mishandling the separation, and a myriad of other actions or inactions.^{16,28} Given their presumed competence in managing disturbed behavior, mental health professionals are more prone to self-blame and self-reproach in these situations, and these unmerited appraisals can be sustained by the attitudes of some of our colleagues. It has long been recognized that patients may transfer feelings of love or hate to their therapists as a consequence of their early experiences

and the treatment situation, a phenomenon known as transference.⁶¹ However, although it may be influenced by such processes, the emergence of feelings of love or betrayal in the treatment relationship should not be summarily reduced to transference explanations.²⁸ This rationale for patients' misplaced attentions has unfortunately fostered a sense of responsibility and guilt in mental health professionals and the precarious assumption that the stalking can be effectively managed within the stalker-therapist relationship.¹⁶ Some mental health professionals also naively assume that their patients cannot become criminals or engage in criminal behavior.

The proliferation of stalking research over the past two decades has given rise to a better informed mental health workforce with the capacity to intervene effectively in stalking cases.⁶² Yet it is evident that some psychiatrists continue to minimize and intellectualize stalking in a therapeutic context, placing themselves and their loved ones at risk of psychosocial and physical harm and compromising their careers. Many such cases are likely to go unreported. Despite the growing evidence base, advice from peers may be ill-informed and counterproductive. Although the research in this area has consistently found that experienced practitioners are equally or more vulnerable to the unwanted attentions of their patients and that stalking by patients is not the product of therapeutic incompetence, psychiatrists continue to contend with the unhelpful or even critical attitudes of their colleagues and employers. Traditional portrayals of clinician-patient liaisons usually emphasize the clinician's exploitation of the patient and an imbalance of power that precludes the patient's victimizing the clinician,⁴² a view that to some extent prevails among our peers and professional registration boards. The failure to recognize that some patients' complaints are malicious and a manifestation of stalking amplifies victims' suffering and, for some disenchanted professionals, it can end careers.

Another female patient accused her psychiatrist of having sexual relations with her in his office during their psychotherapy sessions. The psychiatrist was mounting a vigorous defense until the patient brought to the local police dried semen from the psychiatrist that she stated had come from her underwear while having sex with him. Felony criminal charges were filed against the psychiatrist after DNA testing, and his license was in the process of being suspended. A rigorous investigation eventually re-

vealed that she had stalked the psychiatrist's home subsequent to the termination of treatment and had found several pairs of his semen-stained underwear in his trash containers—he was on a weight loss program, and his wife was throwing away his excessively large underwear in their trash. When confronted by the police, the ex-patient admitted to stealing the underwear and scraping semen from it. The charges against the psychiatrist were dropped.

For stalking victims, including health care professionals, there is now a wealth of specific information and intervention guidelines.^{16,17,28,63–65} As Maclean et al.³³ note, the U.K. Royal College of Psychiatrists has commendably established the Psychiatrists' Support Service to assist victimized psychiatrists.⁶⁶ There is often reluctance on the part of stalked clinicians to pursue legal remedies, at least in cases that do not involve physical injury. Many clinicians believe they should have a high tolerance for the criminal behavior of patients, but such clemency may not be in the best interests of the professional, his family, and the practice staff, or indeed in the best long-term interests of the patient.²⁸

Since would-be stalkers have no specific distinguishing features, stalking is not entirely avoidable in therapeutic settings, unless of course one stops seeing patients.²⁸ Yet, health care professionals can reduce the risks and minimize damage by taking immediate steps to protect their privacy by removing as much personal information as possible from the public domain and minimizing the use of social networking sites. They should never ignore the emergence of stalking behaviors in their patients, keep good records, and, as a priority, seek advice. It is often appropriate to alert other parties, including staff and family members, as their support is crucial, and ignorance places them at risk.¹⁶ In certain situations, a waiver of privilege may hold wherein the psychiatrist can report the patient to the police if he or she poses a serious threat of violence toward the psychiatrist, a Tarasoff situation in which the psychiatrist is also warning himself. Jurisdictional differences will apply in this context, and psychiatrists are urged to consult carefully with an attorney before such privilege is waived.

Our training does not exempt us from stress reactions or maladaptive coping mechanisms, and rather than discounting or reframing one's distress or resorting to self-therapy, it is reasonable to seek treatment. Our profession, law enforcement agencies,

and regulatory bodies continue to have urgent educational and training needs in the area of stalking, particularly in understanding its manifestations, harmful impacts, and optimal interventions. Repeated intrusions, intimidation, and personal upheaval are not part of the job, and colleagues who have the misfortune to experience them deserve our sympathy and support, not our criticism. We have made major advances in our understanding of stalking, which stem predominantly from the efforts of mental health researchers. Victims of stalking should no longer have to feel forsaken, particularly in a profession such as ours.

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