Stalking, Threatening, and Harassing Behavior by Psychiatric Patients Toward Clinicians

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The authors surveyed hospital staff to determine how often they had been the target of stalking, threatening, or harassing behavior (STHB) by patients, what strategies they had used to manage the behavior, and their evaluation of various interventions. A written survey about STHB by patients was sent to all clinical staff ($N = 82$) of the adult inpatient psychiatric service of an urban university hospital. Clinicians who had been the target of such behavior were interviewed about their experiences. Of the 62 staff members who completed the survey, 33 (53%) had experienced some type of STHB during their career. Seventeen of these 33 individuals agreed to be interviewed and provided information about 28 cases of STHB. Staff often rated the behavior as upsetting and disruptive. The frequency with which staff used various management strategies and their perceived effectiveness are described. The results suggest that although severe cases are relatively rare, milder forms of STHB are experienced by a substantial proportion of clinicians and have significant adverse consequences. A variety of management options are available to the clinician when confronted with this situation.

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Although clinicians who provide care to severely mentally ill patients must be prepared to evaluate and manage aggressive behavior, deciding which course of action is best in a given situation is often difficult. The decision is especially challenging in situations in which patients stalk, threaten, or harass clinicians.[1] Stalking has gained widespread attention in the media, and descriptive research has begun to identify demographic and clinical characteristics of those who engage in such behavior.[2–5] With few exceptions, however, research has described perpetrators who may be atypical of those who most frequently target clinicians—for example, a series of cases from the clinical files of experts or descriptions of incarcerated individuals who may constitute extreme groups for whom efforts at management have failed.

Although research on the perpetrators of stalking is in its early phases, even less information is available on the experiences of victims of stalking. Nevertheless, data suggest that the impact is often substantial.[6] According to a large community survey,[7] more than 30 percent of female victims and 20 percent of male victims sought psychological counseling as a result of the experience. Similarly, clinicians who have been stalked by patients have reported experiencing financial losses, missing time from work, and increased stress and worry.[8]

Those who have conducted such research or have extensive clinical experience in the topic have proposed plausible strategies for managing stalking, threatening, and harassing behavior (STHB).[8–10] Yet, few empirical data are available to show the frequency with which groups of clinicians experience the problem, the strategies that clinicians use when confronted with these behaviors, or the consequences of implementing various management strat-

egies. This basic descriptive information is needed as a background for the development of evidence-based practice in this domain. We began to address this need by surveying and interviewing hospital staff about their experiences of having been stalked, threatened, or harassed by patients and their opinions about the effectiveness of strategies they had used in managing patients who had engaged in such behavior. To our knowledge, this is the first study to sample all clinicians from a clinical service treating severely mentally ill patients in a civil (noncriminal) setting about their experiences with patients who stalk, threaten, or harass them.

Methods

We invited all staff members ($N = 82$) affiliated with an urban, university-based psychiatric inpatient unit to complete a written survey about the STHB of patients. We selected the study group from this setting to obtain a cross section of mental health providers in terms of professional background and level of experience. Of the 82 staff members who were asked to participate, 49 (60%) were regular staff and 33 (40%) were *per diem* staff. Forty-five (92%) of the regular staff and 17 (52%) of the *per diem* staff completed the survey, yielding a response rate of 76 percent ($n = 62$). Forty-one (66%) were women and 21 (34%) were men. Six (10%) were 20 to 29 years of age, 16 (26%) were 30 to 39, 20 (32%) were 40 to 49, and 20 (32%) were 50 or older. Forty-eight (77%) were white, three (5%) were African American, eight (13%) were Asian, two (3%) were Hispanic, and one (2%) was of unspecified ethnic background. Forty (65%) were in nursing, nine (14%) in psychiatry (resident and attending), five (8%) in social work, five (8%) in psychology, and three (5%) in other professions. Years of clinical experience ranged from 2 to 43 (mean ± SD, 16.87 ± 9.61).

We developed a survey that asked respondents to indicate whether they had, at any time during their training or careers as mental health professionals, directly experienced a broad range of aggressive behavior by patients, including physical assault, destruction of property, threats of harm, harassing phone calls, unwanted approach, surveillance, and being followed. Using the definitions of Meloy and Gothard[12] for stalking and obsessional following, respondents were also asked whether they had ever been "the target of a patient's abnormal or long-term pattern of threat or harassment (defined as more than

one overt act of unwanted pursuit which was perceived by you as being harassing)" and whether a patient had ever "willfully, maliciously, and repeatedly followed and harassed [the clinician] in a way that threatened [the clinician's] safety" (Ref. 12, pp 258–9). Because problems associated with management of aggression in controlled treatment settings differ from those in outpatient contexts, we asked participants to exclude any behavior that took place during the course of treatment in an inpatient or locked unit (e.g., psychiatric inpatient unit, emergency room, crisis intervention unit, residential treatment facility, jail, or prison). At the end of the survey, we asked the respondents whether they would be willing to discuss their experiences.

Seventeen (52%) of 33 staff members who indicated that they had been the target of a patient's STHB agreed to be interviewed by an author (D.A.S.). Thirteen interviews were conducted in person, and four were conducted by telephone. Thirteen (76%) of these 17 staff members were women and four (24%) were men. Twelve (71%) were white, one (6%) was African-American, one (6%) was Asian, two (12%) were Hispanic, and one (6%) was of unspecified ethnic background. At the time they experienced a patient's STHB, five clinicians (29%) were aged 30 to 39, six (35%) were aged 40 to 49, and six (35%) were aged 50 years or more. Their professional disciplines included nursing ($n = 7$; 41%), psychiatry ($n = 3$; 18%), social work ($n = 3$; 18%), psychology ($n = 1$; 6%), and other professions ($n = 3$; 18%).

The staff member, to be eligible for the interviews, had to have indicated on the written questionnaire that he or she had been the target of STHB by a patient ($n = 33$). To evaluate for possible selection bias, we compared those victims who did ($n = 17$) and did not ($n = 16$) agree to be interviewed on relevant background characteristics, by means of chi-square analyses for categorical variables and t tests for continuous variables. The two groups did not differ significantly ($p < .05$) in sex, ethnic background, age, professional discipline, employment status, years of experience, or type of STHB that they had experienced. These findings provide no support for the possibility of selection bias affecting which of the staff who had been the target of STHB by their patients agreed to be interviewed about their experiences.

The interview was semistructured and developed by us to gather detailed information about each case of STHB. The interviewer inquired about demographic and clinical characteristics of the patient, the treatment setting, and the staff member's professional relationship with the patient. The staff member was asked to provide a detailed account of the patient's behavior, to explain why he or she thought the patient engaged in such behavior, and to indicate what management strategies were used and how effective the staff member believed each of the interventions was in dealing with the situation. In addition, each staff member was asked to rate, on a scale of 1 (not at all) to 5 (extremely), how subjectively upsetting and disruptive the situations were.

Data were collected in the fall of 1996 and winter of 1997. Before participating in the study, staff members were given a written description of the project. All participants gave informed consent. The study was approved by the Committee on Human Research of the University of California, San Francisco.

Data analysis consisted of presentation of descriptive statistics and case examples illustrating patients' STHB and interventions used by the staff in response.

Results

Rates of Victimization

Thirty-three (53%) of the 62 staff members who responded to the written survey reported having been the target of any STHB outside the hospital or other locked settings during their careers. Table 1 shows that more severe acts, such as stalking, obsessional following, and physical attacks were relatively rare. However, behaviors such as threats, harassing

Table 1 Proportion of 62 Clinicians Who Experienced Stalking, Threatening, or Harassing Behavior by Patients*

Behavior	n	%
Physical attacks	4	6
Destruction of property	3	5
Threats of harm	12	19
Threats (other than harm)	13	21
Harassing phone calls or letters	16	26
Unwanted following, approach, or surveillance	12	19
Other harassing behavior	20	32
Obsessional following	5	8
Stalking	2	3
Any stalking, threatening, or harassing behavior	33	53

* These data exclude behavior that took place in inpatient or other locked settings.

Table 2 Demographic and Clinical Characteristics of 28 Patients Who Stalked, Threatened, or Harassed Staff Members*

Characteristic	n	%
Sex		
Male	22	79
Female	6	21
Age (y)		
20–29	7	25
30–39	11	39
40–49	6	21
≥50	4	14
Ethnic background		
White	22	79
African-American	2	7
Asian	3	11
Unknown	1	4
Treatment setting		
Outpatient or former outpatient	7	25
Former inpatient	18	64
Other	3	11
Diagnosis†		
Mood disorder	12	43
Schizophrenia	14	50
Substance abuse/dependence	8	29
Personality disorder/traits	13	46

* Data are based on interviews of 17 staff victims of STHB by patients.
† Total exceeds 100% due to comorbidity.

telephone calls or letters, and unwanted following or approach were relatively common.

The 17 staff members who were interviewed in detail about their experiences described 28 patients who had engaged in STHB. The mean (±SD) number of patients identified per staff member was 1.6 ± 0.87 (range, 1–3). The staff described behavior by the 28 patients that included physical attacks ($n = 1$; 4%); destruction of property ($n = 1$; 4%); threats of harm ($n = 5$; 18%); harassing phone calls or letters ($n = 14$; 50%); unwanted following, approach, or surveillance ($n = 13$; 46%); and other harassing behavior ($n = 6$; 21%). The duration of the patient's behavior ranged from a single incident to three years (single incident, $n = 9$, 32%; 2–14 days, $n = 6$, 21%; 15–30 days, $n = 2$, 7%; 1–3 months, $n = 3$, 11%; more than 3 months, $n = 8$, 29%). Although much of the longer-duration behavior was intermittent, one case involved severe and persistent behavior for approximately 3 years.

Table 2 shows the demographic and clinical characteristics of the 28 patients. Most of the patients were white men less than 40 years old. They had a variety of psychiatric disorders, commonly including personality disorders, substance abuse, and/or major mental illness, and most had been treated formerly by the staff members in an inpatient unit.

Staff Opinions About Motivations for Patients' Behavior

Examination of staff members' stated opinions about why the 28 patients engaged in STHB revealed that 61 percent ($n = 17$) exhibited angry, retaliatory behavior in response to some form of perceived mistreatment, 25 percent ($n = 7$) incorporated the clinicians into delusional beliefs, and 14 percent ($n = 4$) had other apparent motives. Events that were perceived as forms of mistreatment included involuntary hospitalization, unwanted discharge, seclusion and restraint, undesirable results of psychological or psychiatric evaluation, and limit-setting. The following case vignettes illustrate this type of behavior.

Case A

A 33-year-old former inpatient with a diagnosis of schizoaffective disorder and polysubstance abuse was standing near a building in his community when he recognized a psychiatric nurse who had been involved in his treatment. He chased her down the street and threatened to kill her for "locking him up for no good reason" and for being involved in his seclusion and restraint.

Case B

A 55-year-old outpatient with a history of combat exposure and substance abuse was evaluated by a psychologist who determined that he was malingering and did not meet criteria for post-traumatic stress disorder (PTSD). As a result, the patient was denied certain financial benefits. After obtaining a copy of the psychological report, the patient threatened to sue the agency and kill the psychologist.

Case C

A 27-year-old former inpatient with narcissistic personality traits and recurrent depression was at a dance club when he approached a psychiatry resident who had treated him during his most recent hospitalization. The patient expressed a romantic interest in the resident and suggested that they begin a sexual relationship. When the resident tried to set appropriate limits, the patient became enraged and stormed out of the establishment, claiming that the resident was trying to "act better" than he. Later that night, the resident discovered that her car windshield had been cracked.

Although less frequent, delusional thinking was noted on occasion as a motivating factor for STHB.

Case D

A 28-year-old man with paranoid schizophrenia began sending letters to his former inpatient therapist to warn her that the world was coming to an end. He thought highly of her and had developed delusions about how the two of them would survive the massive destruction. He also tried to obtain information about the therapist's spouse.

Staff Reactions

Although only one of the 17 staff members who were interviewed reported being physically attacked by a patient, more than half of the cases of STHB were rated (on a scale of 1 to 5) by the staff member as either very or extremely upsetting (not at all upsetting, $n = 1$, 4%; a little upsetting, $n = 3$, 11%; moderately upsetting, $n = 9$, 32%; very upsetting, $n = 8$, 29%; extremely upsetting, $n = 7$, 25%). Similarly, more than one-third of the cases were considered either very or extremely disruptive (not at all disruptive, $n = 2$, 7%; a little disruptive, $n = 6$, 21%; moderately disruptive, $n = 10$, 36%; very disruptive, $n = 8$, 29%; extremely disruptive, $n = 2$, 7%). Staff ratings of the extent to which the situation was upsetting and disruptive correlated highly ($r = 0.76$, $n = 28$, $p < .001$). Although none of the patients' characteristics (i.e., age, gender, ethnic background, treatment status, or diagnosis) was strongly associated with staff ratings of the extent to which the situation was upsetting or disruptive, duration of the patient's behavior appeared to be an important factor. Six (86%) of the 7 situations rated extremely upsetting and 7 (70%) of the 10 most disruptive situations had a duration of at least three weeks.

Management Strategies: Types and Perceived Effectiveness

Staff members responded to the situations in a variety of ways. Table 3 shows the frequency with which various strategies were used, along with ratings of the perceived effectiveness of each strategy by the clinicians who had used it. The most common responses included notifying other people, such as co-workers, team leaders, and supervisors. Other frequent responses included confronting the patient about his or her behavior and telling the patient to stop, avoiding or discouraging contact with the patient, discussing the situation in a formal staff meeting, and notifying the receptionist. Less frequent responses included notifying the police or hospital

Table 3 Staff Members' Evaluation of Management Strategies for 28 Cases of Stalking, Threatening, or Harassing Behavior by Patients*

	Number of Cases in Which Strategy Was Used		Perceived Effectiveness of Strategy When Used					
			Made Things Better		No Impact		Made Things Worse	
	n	%	n	%	n	%	n	%
Notified coworkers (informally)	24	86	19	79	4	17	1	4
Notified attending physician, clinical director, team leader, or supervisor	23	82	18	78	3	13	2	9
Patient directly confronted about his/her behavior and told to stop	18	64	10	56	5	28	3	17
Contact with patient actively avoided or discouraged	17	61	15	88	0	0	2	12
Situation discussed during formal staff meeting	17	61	11	65	5	29	1	6
Notified front desk/reception	12	43	9	75	2	17	1	8
Patient prohibited from entering the building or being on campus	9	32	8	89	0	0	1	11
Notified police	8	29	8	100	0	0	0	0
Notified security	7	25	7	100	0	0	0	0
Patient referred elsewhere for treatment	7	25	5	71	1	14	1	14
Consultation sought from an expert	5	18	5	100	0	0	0	0
Patient hospitalized	4	14	2	50	1	25	1	25
Patient escorted out of the building	4	14	3	75	0	0	1	25
Patient arrested or taken into legal custody	1	4	1	100	0	0	0	0
Restraining order obtained against patient	1	4	1	100	0	0	0	0

* Based on interviews of 17 staff members who described responses to a total of 28 cases of STHB by patients.

security and obtaining a restraining order against the patient.

Although the percentages are based on a small number of cases, all the staff members who used the following strategies thought that the strategies were effective: notifying the police or hospital security, seeking consultation from an expert, having the patient arrested or taken into legal custody, and obtaining a restraining order against the patient. In contrast, only approximately half of the staff members who reported directly confronting the patients about their behavior and telling them to stop or hospitalizing the patients indicated that doing so was helpful. Awareness of a variety of strategies appeared useful, so that if one was unsuccessful, others were available. In the following sections, we describe several strategies along with case vignettes that illustrate their implementation.

Examples of Implementation of Management Strategies

One strategy involved notifying other people such as coworkers, team leaders, supervisors, receptionists, and hospital security. In addition to yielding support from others, this strategy allowed others to participate in protecting the staff member from the perpetrator.

Case E

A 23-year-old male patient, who had been discharged with diagnoses of major depression and borderline personality disorder, repeatedly called a nurse during her shift. The nursing staff agreed that the affected staff member would not pick up the telephone, in case the caller was the former patient. The patient called three nights in a row. Each time, another nurse would state that the nurse was not available and that, in any event, she was no longer involved in the treatment of the patient and therefore could not speak to the patient. The patient was advised to call the emergency room or his own therapist. The patient eventually stopped calling.

Another strategy involved direct contact with the patient to set limits on the behavior and tell the patient to stop. This often included clarification and mediation to defuse the behavior.

Case F

A 24-year-old man with a diagnosis of bipolar disorder and antisocial personality disorder was arrested for committing a bizarre crime. He was evaluated by a psychiatrist retained by his defense attorney in an effort to persuade the court to consider mandating treatment as an alternative to sentencing him to in-

carceration. The defense attorney showed the psychiatric report to the defendant, which included a description of the defendant's manic delusional beliefs involving various Hindu gods and goddesses. The defendant, in response to perceived inaccuracies in the report, made multiple threatening calls to the psychiatrist. The psychiatrist did not return the telephone calls and called the defense attorney and advised him to tell the defendant to stop calling. The defendant kept calling the psychiatrist, and at one point he even arrived unannounced at the psychiatrist's office. Finally, a meeting was set up with the psychiatrist, the attorney, and the defendant. During that meeting, the defendant stated that he was angry because the psychiatrist had referred to one of the Hindu deities as a woman rather than a man, a terrible insult. The psychiatrist acknowledged that he had made this mistake because he had no knowledge about Hindu gods and apologized for the error. The defendant's anger subsided, and he did not contact the psychiatrist again.

Case G

A 29-year-old man with paranoid schizophrenia repeatedly left messages for a 28-year-old female social worker who had been involved in his inpatient treatment. He stated that he wanted to date her. The social worker tried ignoring the calls, but they continued. Once, when the patient called, the social worker picked up the telephone. When the patient asked her for a date, she replied that she was sorry but that she had a boyfriend and, in fact, was engaged to be married in one month. The patient apologized, and said that he had not known that she "was already taken." He never called her again. (Note: Although it could be argued that a more appropriate response from a clinical and therapeutic standpoint would have been to delineate the boundaries of the therapeutic relationship, from a safety perspective, the staff member who described having made this communication reported that it was followed by a positive outcome.)

A third strategy involved obtaining a restraining order. This was a fruitful response to the STHB of a patient who had something to lose by being arrested—that is, criminal charges would have had a negative impact on the patient's personal and professional reputation.

Case H

A 43-year-old accountant with major depression and borderline personality disorder began verbally abusing his psychiatrist because she refused to write him a letter to recommend disability payments and refused to increase the frequency of their sessions. When she attempted to set limits, he escalated the threats and began leaving threatening messages on her answering machine. His girlfriend, a businesswoman, also started to leave threatening and demeaning messages about how incompetent the psychiatrist was. The psychiatrist decided to terminate treatment and made appropriate referrals. She discussed this with both the patient and his girlfriend and confirmed the discussions in a letter. The phone messages and verbal threats continued, even after the treatment was terminated. After consultation with an expert in stalking and violence, the psychiatrist went to court and obtained a restraining order against the patient and his girlfriend. Subsequently, the threats and harassing phone calls stopped.

In contrast to these successful interventions, potentially useful management strategies were not considered to be effective in every situation by staff who used them. In fact, staff believed that some interventions made things worse, as illustrated by the following vignette.

Case I

A 25-year-old man with a diagnosis of delusional disorder, erotomanic subtype, developed the false, fixed belief that he had had an affair with his therapist and was going to marry her. He persistently came to the treatment facility stating that he wanted to see her. He obtained her home address and telephone number. He left up to 20 messages per day on her answering machine, peered through the windows of her home, and called from the pay phone across the street from her home. Eventually, he became more hostile, smashing her car window and writing letters including statements such as, "If I can't have you in life, I will have you in death."

The therapist's initial response was to attempt to talk to the patient and tell him to stop his behavior. However, contact of any sort simply escalated his behavior. The therapist informed her coworkers about the situation, and it was discussed in a formal staff meeting. Other staff members attempted to limit the patient's behavior, but their efforts were also counterproductive. The situation improved some-

what when the police arrested the man for trespassing, but deteriorated when they let him go "because he was crazy." Only when the staff member moved and changed her telephone number was she able to escape this patient's persistent STHB.

Discussion

The results of our written survey suggest that, whereas severe forms of STHB directed at mental health clinicians by patients are relatively rare, milder forms of harassment are commonplace. Three percent of staff members in our study reported that they had been stalked by a psychiatric patient, and 8 percent were the target of a patient's obsessional following. In contrast, more than half of the clinicians in our study reported that they had experienced some form of STHB by one or more of their patients during their careers.

Interviews with staff who were the targets of STHB showed that most rated the episodes as upsetting and disruptive. This was especially true of situations that had a longer duration. Several respondents indicated that it was unsettling not to know when or whether the patient would engage in future harassment. This type of siege mentality (i.e., the expectation of future aggression or violence, regardless of its expected severity) has been identified as an important variable for explaining the negative cognitive schemas exhibited by victims of domestic violence, which can contribute to post-traumatic stress reactions.[6,13] Attention to the staff's responses suggests the need for intervention to reduce the risk of stress-related emotional problems that may result from the patient's behavior. These may include training in the area of violence and stalking, availability of individual crisis counseling and postincident referral for victims, consultation with law enforcement and experts in STHB, and development of policies that support staff reporting instances of STHB.[14]

The patients who stalked, threatened, or harassed staff members were similar to those reported in samples of stalkers in other settings, in that they were primarily men with a variety of psychiatric conditions, including a substantial proportion with personality disorders and/or substance abuse or dependence.[2,5,9,12,15] More than half were former inpatients. In accord with the assertion of Lion and Herschler[9] that patients who stalk clinicians do so because they feel misunderstood, wronged, or mistreated, more than half of the patients in our study

exhibited angry, retaliatory behavior in response to some form of perceived mistreatment. Precipitating events included involuntary hospitalization, unwanted discharge, seclusion or restraint, undesirable results of psychological or psychiatric evaluation, and limit-setting around professional boundaries. Nevertheless, other factors (e.g., delusional beliefs) sometimes played a role. Overall, these findings indicate that stalking is a complex, multidimensional behavior.

Our data suggest that there is no panacea for management of STHB by patients. Any interventions may or may not be effective in the individual case. In approaching the management of STHB toward clinicians by patients, our findings suggest the value of having a repertoire of responses. This permits flexibility in responding, so that if one intervention fails, other plausible strategies may be implemented.

The most common response made by staff members in our study was to tell coworkers or supervisors about the situation. Most of the staff members did so, and most of those thought that it made things better. However, some staff members did not share the information with their coworkers or supervisors. Possible reasons may be that staff minimized the dangerousness of the situation, thought they could handle the situation on their own, were embarrassed or thought they would be blamed for the incident, or feared that disclosure might result in actions that would make things worse. Future research is needed to determine the factors that are associated with a staff member's reluctance or willingness to share such information, as well as steps supervisors can take to assure that disclosure is indeed helpful to the staff member. Denial and minimization are common responses of clinicians to STHB by patients, and disclosure can be a first step in resolving the problem.[9] Moreover, colleagues can provide support and new perspectives on the problem and its management.

Another common response was limit-setting through directly confronting the patient about his or her behavior. This strategy received mixed reviews by staff who used it. The intervention appears to require considerable accuracy in case formulation. In some situations it can be effective in stopping the patient's behavior; however, it may result in further escalation.

Although the strategy was rarely implemented by staff members in our study group, some study participants' responses suggest the potential utility of involving the legal system. When patients violate the

boundaries of the treatment relationship by engaging in aggressive behavior toward clinicians outside of specially contained situations, such as locked hospital wards, legal rather than clinical responses represent an option for managing the behavior. These interventions may include notifying the police, filing restraining orders against the patient, or depending on the circumstances, even arrest. As reviewed elsewhere,[17] potential benefits of legal responses include, on the one hand, protecting staff, deterring future aggression, and helping patients take responsibility for their own behavior. On the other hand, some have argued that legal sanctions can represent the acting-out of countertransference, may invite lawsuits by patients, and can undermine the possibility of a therapeutic alliance. In our study, only two staff members took action that led to the filing of a restraining order or precipitated the arrest of the patient. In one case, arresting the patient was associated with cessation of the STHB until he was released. In another case, filing a restraining order was followed by discontinuation of the patient's STHB. Further research is needed on the indications and contraindications for using legal interventions with psychiatric patients who stalk, threaten, or harass mental health clinicians.

Although various subtypes of people who engage in STHB have been proposed,[2,3,15,16,18] to our knowledge, no studies have been undertaken to evaluate whether differential responses to these subgroups reliably lead to desirable outcomes. The sample in our study was not large enough to conduct such an analysis. However, we believe that the opinions of staff members reported herein may be useful to clinicians in identifying options that are of potential benefit in managing such behavior in patients. Further research is needed to systematically evaluate the usefulness of these approaches.

The purpose of our study was to describe the scope of the problem of STHB toward clinicians among their patients and to generate hypotheses. The study has a variety of limitations. We sampled staff members of a single psychiatric inpatient unit to learn about their experiences in managing STHB by patients. Further research is needed to determine the extent to which our findings are generalizable beyond this setting. Although the total sample was not large, it included staff from an array of disciplines and of various levels of experience. In contrast to most previous research, we did not select extreme

cases of STHB by those who have been incarcerated or from the case files of an expert on stalking and violence. Those sampling methods may identify more severe cases and/or those that have not responded to management interventions. It is likely that the types of cases reported in our study are more characteristic of the STHB experienced by mental health professionals. In addition, our sampling method permits the identification of both effective and ineffective management strategies.

Another limitation of our study is that only half of the staff members who indicated that they had been the target of STHB by patients agreed to be interviewed. It is possible that factors such as fear and denial could have affected this response rate, so that we were able to interview only staff members who felt comfortable discussing their experiences. It may be that the staff who indicated on the survey that they had been the target of this type of behavior by patients but declined to be interviewed about it had achieved less favorable results in their efforts to manage the behavior.

Finally, staff members' reports that in their personal experience particular interventions were helpful can be viewed as only a first step in identifying potentially effective interventions. Further prospective research is needed for scientific evaluation of the situations in which these suggested management strategies are and are not effective.

In sum, the results of this study suggest that a substantial proportion of hospital staff members are at risk at some time during their careers of becoming the targets of STHB by patients. We have identified several management strategies that may be helpful in responding to this problem.

References

1. Dubin WR, Lion JR (editors): American Psychiatric Association Task Force Report 33: Clinician Safety. Washington, DC: American Psychiatric Association, 1993
2. Meloy JR: The psychology of stalking, in The Psychology of Stalking: Clinical and Forensic Perspectives. Edited by Meloy JR. San Diego, CA: Academic Press, 1998, pp 1–23
3. Mullen PE, Pathe M, Purcell R, Stuart GW: Study of stalkers. Am J Psychiatry 156:1244–9, 1999
4. Palarea RE, Zona MA, Lane JC, Langhinrichsen-Rohling J: The dangerous nature of intimate relationship stalking: threats, vio-

lence, and associated risk factors. Behav Sci Law 17:269–83, 1999

5. Sandberg DA, McNiel DE, Binder RL: Characteristics of psychiatric inpatients who stalk, threaten, or harass hospital staff after discharge. Am J Psychiatry 155:1102–5, 1998

6. Pathe M, Mullen PE: The impact of stalkers on their victims. Br J Psychiatry 170:12–17, 1997

7. Tjaden P, Thonnes N: Stalking in America: findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice, Centers for Disease Control and Prevention, 1998

8. Romans JS, Hays JR, White TK. Stalking and related behaviors experienced by counseling center staff members from current or former clients. Prof Psychol 27:595–9, 1996

9. Lion JR, Herschler JA: The stalking of clinicians by their patients, in The Psychology of Stalking: Clinical and Forensic Perspectives. Edited by Meloy JR. San Diego, CA: Academic Press, 1998, pp 163–73

10. Meloy JR: The clinical risk management of stalking: "Someone is watching over me. . . ." Am J Psychother 51:174–84, 1997

11. White SG, Cawood JS: Threat management of stalking cases, in The Psychology of Stalking: Clinical and Forensic Perspectives. Edited by Meloy JR. San Diego, CA: Academic Press, 1998, pp 295–315

12. Meloy JR, Gothard S: A demographic and clinical comparison of obsessional followers and offenders with mental disorders. Am J Psychiatry 152:258–63, 1995

13. Dutton MA, Burghardt KJ, Perrin SG, Chrestman KR, Halle PM: Battered women's cognitive schemata. J Trauma Stress 7:237–55, 1994

14. Flannery RB: The Assaulted Staff Action Program (ASAP): Ten year empirical support for critical incident stress management (CISM). Int J Emerg Ment Health 3:5–10, 2001

15. Harmon RB, Rosner R, Owens H: Obsessional harassment and erotomania in a criminal court population. J Forensic Sci 40:188–96, 1995

16. Zona MA, Palarea RE, Lane JC: Psychiatric diagnosis and the offender-victim typology of stalking, in The Psychology of Stalking: Clinical and Forensic Perspectives. Edited by Meloy JR. San Diego, CA: Academic Press, 1998, pp 69–84

17. Rachlin S: The prosecution of violent psychiatric inpatients: one respectable intervention. Bull Am Acad Psychiatry Law 22:239–247, 1994

18. Brown GP, Dubin WR, Lion JP, Garry LJ: Threats against clinicians: a preliminary descriptive classification. Bull Am Acad Psychiatry Law 24:367–76, 1996