Psychiatrists' Experiences of Being Stalked: A Qualitative Analysis

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Stalking is a well-recognized social phenomenon, one that particularly affects health care professionals, especially psychiatrists and other mental health workers; however, the nature and effects of stalking of psychiatrists have not been examined in detail. This study is a qualitative thematic analysis of the free-text responses of 2,585 psychiatrists in the United Kingdom (approximately 25% of all U.K. psychiatrists), almost 11 percent of whom described being stalked according to a strict research definition, and 21 percent of whom perceived themselves as having been stalked. It demonstrates that threat minimization, negative psychological impact, awareness of vulnerability, and difficulty obtaining help were major themes in how psychiatrists viewed their experiences of being stalked. It shows how some psychiatrists coped better than others and makes suggestions for appropriate professional support.

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Stalking is a notorious social phenomenon and criminal offense. The sustained unwanted contact, intimidation, and communication involved often significantly restrict a victim's life and have serious psychological consequences.[1] Between 2 and 15 percent of people in Western populations report being stalked,[2–8] and there is emerging evidence to suggest that health care professionals are at higher than average risk, especially mental health professionals.[9–23] Psychiatrists in particular may be at increased risk.[22,24,25] Whyte *et al.*[26] recently investigated stalking experiences of members of the U.K. Royal College of Psychiatrists and found a stalking victimization prevalence of 10.7 percent by an objective definition and 21.3 percent by self-report; 56 percent of the victims were male, which was not significantly different from the proportion of Royal College members who are male (60%).

In the general population, stalking causes both psychological distress and altered behavior, whether or not an assault occurs.[27] Mental disorders, including posttraumatic stress disorder, have been reported in stalking victim studies.[27–29] A victim's perspective on a traumatic event can mediate its effect. The reactions of psychiatrists who are stalked, whether by a patient or someone else, are likely to be influenced by their perceived understanding of why the stalking occurred. There is no evidence that they are more or less likely than other victims of stalking to have negative psychological or psychiatric consequences. However, they may be perceived to be less vulnerable to these consequences and may therefore receive less support. In the general population, victims of stalking report an equal number of positive and negative reactions to their requests for help from police,[30] and there is also great variation in the amount and type of support offered by organizational support services. Infield and Platford[31] suggested that perceived negative reactions by the police may be due in part to difficulties in acquiring sufficient evidence to charge an individual with a crime where there has been, or is, a relationship between the alleged perpetrator and the victim. Therapeutic relationships with patients are central to the work of psychiatrists.

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In their study of U.K. psychiatrists, Whyte *et al.*[26] found that those who had been stalked experienced a variety of negative impacts, including anxiety and fear (experienced by 65% of victims), difficulty sleeping (19%), loss of motivation or enjoyment in life (7% and 11%, respectively), ill health (37%), and symptoms of mental disorder (5%). In the present study, we examined psychiatrists' experiences of being stalked in qualitative detail.

Method

Data Collection and Participants

All U.K.-based psychiatrists formally affiliated with the Royal College of Psychiatrists in June 2007 (members, associates, retired practitioners, and premembership psychiatric trainees) were sent an invitation to participate in the study by letter and (where possible) e-mail. Those who did not initially respond received a reminder invitation.

Members who expressed an interest were sent information on the study, details of sources of help for victims of stalking, and a questionnaire, by letter, e-mail, or website according to preference. The 51-item questionnaire consisted of an initial screening section and a more detailed questionnaire for those who had been stalked. A quantitative analysis of responses to 42 of these questions is reported elsewhere.[26] The remaining nine questions were open-ended, free-text responses, allowing participants to describe their experiences and perceptions of stalking. These questions were not mandatory, and some participants made no response. The questions were as follows:

In the screening section, after a series of tick boxes asking about whether respondents have experienced certain types of stalking behavior, and if so, how often:

> Please use this box to tell us anything else you think important at this stage.

In the detailed description of the stalking section:

> Please use this box to tell us anything about the behaviors you experienced that is not covered by the questions above (for example, whether third parties were involved).

At the end of the section covering the number of episodes of stalking:

> If there is anything you would like to tell us about any other episodes of stalking, please write it here.

In the section asking for information about the stalker, if known:

> Please give any information you would like to relating to any possible mental disorder [that the respondent believes the stalker to have, for instance because the individual is the respondent's patient].
>
> Please use this box to tell us anything else about the stalker that you think important (for example, occupation).

In the section asking about who or which agencies helped the respondent:

> If so, please tell us what help you received.
>
> What was the outcome of this help (e.g., call barring, admission, injunction, prison)?

In the section asking about the impact of the stalking on the respondent:

> If you experienced mental disorder, and feel comfortable doing so, please tell us about it.

At the end of the section asking for opinions on a specific support service for victims of stalking:

> If you said no, why not? If yes, what help should it provide? Would it have helped you, and if so, how?

Data Analysis

Responses to those nine free-text questions were analyzed by using the thematic analysis method described by Attride-Stirling.[32] This atheoretical, qualitative research procedure requires the researcher first to familiarize himself with the data, then to code each datum (that is, to label it with a term indicating how the researcher has interpreted it), and then to look for themes within the coded data: concepts that occur repeatedly and can therefore be deemed more significant than those that do not. The researcher must repeat the coding and identification of themes several times, the aim being that, with each iteration, the coding becomes more consistent and systematic and the themes more clearly defined and delineated. A hierarchy of themes is usually identified, and in this case they were termed Basic Themes, Organizing Themes, and Global Themes, which were constructed into networks and validated by comparison with the original data. Extracts of the original data are quoted below as illustrations of each theme.

L.M. undertook the thematic analysis, consulting the other authors at intervals to check the validity of the codes and themes identified and to minimize individual bias. Themes were identified from the free-text responses of all those who self-reported stalking or who met one or both of the Mullen criteria for stalking,[23,33] which are first, 10 or more inci-

dents of stalking behavior, and second, a time frame of occurrence of no less than two weeks.

When considering subjects' attitudes, these themes were compared with themes derived from the few free-text responses by those who had not been stalked, either by self-report or by the Mullen criteria.

Ethics Approval

Ethics approval was obtained from the Ealing and West London Mental Health Research Ethics Committee. The work was also approved and monitored by both the Royal College of Psychiatrists and by the Research and Development Department of West London Mental Health NHS trust.

Results

Descriptive Data

Of 10,429 College members, 2,585 individuals responded to the survey, a response rate of 24.8 percent. Of these, 551 (21.3%) indicated that they regarded themselves as ever having been stalked. Two hundred seventy-six (10.7%) met both of the Mullen criteria, and 589 (22.7%) met at least one of them. Taking the overlap between these groups into account gave a total data set for the qualitative analysis of 601 respondents who regarded themselves as being stalked, or met one or both of the Mullen criteria.

In the results that follow, Global Themes and Organizing Themes are shown at the beginning of each section; Basic Themes are in *italic* within each section. A summary of the themes is shown in Table 1.

Table 1 Summary of Themes Identified

- Global theme: what constitutes stalking?
  - Organizing theme: stalking as a subjective construct
    - Perceptions
    - Level of threat
  - Organizing theme: hierarchy of threat to guide classification
    - Linguistic distinction between stalking and harassment
- Global theme: minimization of threat
  - Organizing theme: stalking is inevitable
    - Stalking is an inevitable consequence of being a psychiatrist
  - Organizing theme: medicalization of stalking
    - Reference to an explanatory psychiatric theory
    - Diagnosis as a justification
    - Humor as a minimizing technique
- Global theme: negative psychological impact of stalking
  - Organizing theme: stalking and anticipated stalking induced distress
    - Fear of the possible consequences
    - Formulating an explanation
    - Hypervigilance
  - Organizing theme: Stalking as a cause of mental disorder
    - Psychopathological consequences
- Global theme: awareness of vulnerability to guide practice
  - Organizing theme: awareness and vulnerability
    - Pre-emptively vigilant
    - Became aware of their vulnerability
  - Organizing theme: responses
    - Preventive behaviors employed in practice
    - Vigilance was the most common response
- Global theme: difficulty getting help when stalked
  - Organizing theme: variations in support
    - Support difficult to access
    - Well supported
  - Organizing theme: distress related to support requests
    - The unsupported often expressed more distress

Global Theme: What Constitutes Stalking?

Organizing Theme: Stalking as a Subjective Construct

There was significant variability in perceptions of what constitutes stalking. In some cases, where both of the Mullen criteria were met and the outcome was significant or long-lasting, some participants still reported that they did not feel that they had been stalked:

> I am unsure whether this was true stalking. I received daily letters for about 30 years and regular birthday and Xmas presents—usually food/chocolate which were delivered by the person concerned to my places of work.

The perception of stalking as an unacceptable approach was mediated by the perceived level of threat. Approaches were less likely to be seen in the context of stalking if they were considered nonthreatening:

> A patient regularly sent me letters and tapes which he had recorded for me. He also gave me a rather unusual present. However I never felt threatened by him as this behaviour stopped as soon as I handed over his care.

Organizing Theme: Hierarchy of Threat to Guide Classification

Stalking in the context of the level of threat also led to the participants' making a linguistic distinction between stalking and harassment, with the former seen as significantly more threatening:

> I would probably call it harassed rather than stalked.

Global Theme: Minimization of Threat

Organizing Theme: Stalking Is Inevitable

There was evidence of a consistent attitude that stalking is an inevitable consequence of being a psychiatrist:

> Unwanted approaches at work seem to me to be part of the JD [job description].

> I regarded [the stalking] and still do as part and parcel of being a psychiatrist!!
>
> [I was spoken to] . . . as if such threatening behaviour should be accepted as "part of the job" in psychiatry.

This was a theme mostly, but not exclusively, expressed by participants who had not been victims of stalking.

Organizing Theme: Medicalization of Stalking

The medicalization of stalking with reference to an explanatory psychiatric theory was also prominent, with many participants referring to inappropriate attachments, substitution, and transference:

> Long term psychotherapy patients make demands during unresolved transference.

Diagnosis as a justification for stalking was also a common theme and was used to minimize the potentially life-threatening experiences that those same participants had described elsewhere:

> Patient did suffer from enduring mental illness.
>
> It later emerged that I was at the center of her delusional (and hallucinatory) system.

Humor as a minimizing technique was also found. It was often used in descriptions of the most extreme experiences, indicating its potential as a coping mechanism:

> Put my house on the market with several local estate agents while I was on holiday (thank goodness he didn't get far with that plan!).

Global Theme: Negative Psychological Impact of Stalking

Organizing Theme: Stalking and Anticipated Stalking-Induced Distress

Some participants expressed fear of the possible consequences of stalking and reported extreme distress due to anticipation of harmful behavior. However, there was also recognition that the anticipated fear was more distressing than the actual stalking. As one participant put it:

> The fear of being stalked in psychiatry is probably greater than the experience.

Formulating an explanation of why an individual was stalked appeared important, as otherwise extreme psychological distress was reported:

> [A]nxious AND afraid, [had thoughts about] "dying an unpleasant death " [s]o it's a bit worrying as to why he is so fixated on me, why me?

Hypervigilance was the most common consequence of stalking, with reports of a long-lasting increase in self-protective behavior:

> I still feel anxious and hypervigilant at times when reminded of this individual.

Hypervigilance was often constant and exhausting:

> They [the stalker] also made me feel generally "burnt out."

The level of distress was linked to the level of support that the psychiatrist received. Some participants responded that they experienced little or no psychological impact because they received a high level of support or supervision:

> No other mental health problems developed. I was supported by colleagues and people had a bit of a laugh about it.

Organizing Theme: Stalking as a Cause of Mental Disorder

Many participants reported psychopathological consequences:

> I developed a major depressive illness, and anxiety with panic attacks.
>
> With hindsight I realised I had an adjustment disorder with some symptoms of PTSD.

These episodes often had long-lasting consequences, with participants reporting any reminder of the stalking results in symptoms:

> Everytime [*sic*] I get a phone call or letter from this person I get uptight and stressed. It's a milder version of PTSD.

Global Theme: Awareness of Vulnerability to Guide Practice

Organizing Theme: Awareness and Vulnerability

Many professionals' awareness of their vulnerability guided their practice and to some extent made them hypervigilant to threats to their privacy. Some participants learned of the possibility of stalking from observation of stalked colleagues or were otherwise pre-emptively vigilant of stalking:

> Psychiatrists are very vulnerable to such distressing and possibly dangerous activity.

However, most of the participants became aware of their vulnerability only when they realized they were being stalked:

> This episode made me feel anxious about my personal security as a female psychiatrist.

Often at this stage, the stalker had found out personal details about the victim.

Organizing Theme: Responses

Preventive behaviors used in practice involved removal from the electoral roll, removal of personal details from websites, call barring and screening, and registering vehicles and services to a hospital address:

> I changed my name and details from work name to married on electoral register.
>
> Have registered my car with community resource address.
>
> [T]ightened up on my non-disclosure with GMC & BMA.

As previously reported, vigilance was the most common response reported and in many cases was severe:

> Anticipatory/phobic anxiety especially in relation to leaving/entering the workplace or answering the phone.
>
> Every time the phone rang I got palpitations.

Global Theme: Difficulty Getting Help When Stalked

Organizing Theme: Variations in Support

Many participants reported encountering the attitude that stalking of psychiatrists is expected by supervisors, clinical staff, and legal authorities, making support difficult to access. These individuals were often angry at not being supported or taken seriously:

> Police and NHS managers did not take the matter seriously and asserted no action would be taken unless a violent offense (against me) took place.
>
> Police eventually agreed to take a statement after I persisted (initially I was told 'it's all part of the job love').

However, some participants felt very well supported:

> Friends and colleagues were great. My employers were helpful and changed my office number.
>
> The stalking stopped when I requested the help of the police, who then visited the patient who I knew and issued the appropriate warning.

Organizing Theme: Distress Related to Support Requests

Individuals who asked for help but felt unsupported often expressed more distress at their experiences than those who received help or those who did not request support:

> My greatest disappointment is up to this day the sheer lack of support and laissez-faire attitude of the senior medical colleagues that I approached for help and advice.
>
> Very upsetting—little support by organization as they had not yet "done anything"!

Conclusions

Several key themes emerged from the data, and all were closely interlinked: subjective perceptions of threat are related to expectations, hypervigilance is the most common response, stalking affects psychopathology and behavior, and victims are often poorly supported.

Subjective perceptions of what stalking is and whether it is threatening appear to be mediated by whether a psychiatrist feels that stalking is an expected occurrence, given the job, with those holding this view appearing to find stalking less threatening. This attitude was also pervasive among participants who had not been stalked and legal authorities, and was a key influencing factor in determining whether any support was received and, when it was, whether it was helpful. For some psychiatrist victims of stalking, it may be that treating this as an expected part of their job helps them cope. However, for others, this attitude in those around them makes seeking and finding appropriate support more difficult. Other coping mechanisms used by some participants included the use of humor or distancing oneself from the stalker's behavior by explaining it using a psychiatric diagnosis or psychological formulation.

Hypervigilance was the most common response to being stalked and was a major source of stress. This seemed to increase with an increasing awareness of the vulnerability of a participant or his family. Few individuals seem to have been aware or accepting of their vulnerability before being stalked. This may be related to their perception of their own ability to cope with the experience of being stalked, or it may be that psychiatrists genuinely do not recognize the potential of their being stalked. Individuals who were preemptively vigilant and employed preventive strategies against stalking were often very successful at avoiding serious consequences of stalking.

We found a significant level of psychopathological consequences and altered behaviors, whether there was a physical element to the stalking or not, as did McEwan *et al.*[27] The psychopathology reported by 15 respondents was consistent with conditions such as anxiety, depression, and posttraumatic stress disorder, as found previously by Kamphuis *et al.*[28] and Pathé and Mullen[29] (although rates of depression and other mental disorders due to occupational stress are known to be high among psychiatrists in general,[34,35] making this finding more difficult to inter-

pret). We were unable to deduce whether the increase in psychopathology was related to poor coping strategies, as we could not determine whether some of the techniques utilized were thinking styles or coping strategies.

We found that psychiatrists who were stalked were often poorly supported by police, supervisors, and managers. However, as also reported by Sheridan *et al*.[30] and Infield and Platford,[31] there was great variation in the level and types of support offered.

These findings suggest that the impact of stalking on psychiatrists is often serious, but can be mitigated by the use of good coping mechanisms, including humor and distancing oneself by using a professional perspective on the stalker. Given the increased prevalence of stalking in this population, ready access to information on the prevalence of stalking, measures that reduce the risk of stalking victimization, and advice on how to respond if it does occur[36,37] would be helpful, particularly to trainee psychiatrists. Since the data reported in this article were collected, the Royal College of Psychiatrists has made available such information, and stalking victimization is one of the problems with which its Psychiatrists' Support Service can help.[38]

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