Professional Psychology: Research and Practice
2015, Vol. 46, No. 4, 277–286
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0735-7028/15/$12.00 http://dx.doi.org/10.1037/pro0000025

# North American Psychologists' Experiences of Stalking, Threatening, and Harassing Behavior: A Survey of ABPP Diplomates

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Most psychologists will be confronted by clients who stalk, threaten, or harass them at some point in their career. Despite the predictability of these challenges, most psychologists feel unprepared for managing them based on the training they receive. This study examined (a) the prevalence and types of stalking, threatening, and harassing behavior (STHB) experienced by highly trained North American psychologists ($N = 157$); (b) differences in the nature and extent of STHB that psychologists practicing in different specialty areas and endorsing different theoretical orientations experience; (c) the types of risk management responses that these experienced clinicians found most (and least) effective; and (d) the personality characteristics of clients who engage in STHB using a clinician-rated standardized measure of personality (SWAP-P). Nearly 3 in 4 psychologists in this sample had been harassed at some point in their career, more than 1 in 5 threatened, and about 1 in 7 stalked. A majority of these highly trained psychologists reported feeling unprepared for these challenges. Results indicate a range of generally effective risk management strategies along with several clinical strategies that appear relatively more likely to make these situations worse. Forensic psychologists experienced STHB at rates nearly twice as high as nonforensic psychologists, and psychologists endorsing a psychodynamic orientation experienced higher rates of STHB than those endorsing a cognitive–behavioral orientation. The implications of these findings are discussed in terms of the need for improved access for psychologists to empirically informed risk management training and recommendations for practice are offered.

*Keywords:* clinical risk management, stalker personality, stalking, stalking psychologists, SWAP

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Psychologists can find themselves in a double bind when patients begin to threaten, harass, and even stalk them. Legal and ethical standards allow for psychologists to disclose confidential information regarding potentially dangerous patients only under fairly narrow circumstances. As a result, it is not uncommon for psychologists to find themselves in a situation in which they are left to protect the confidentiality of a patient that is causing them fear—in fact, surveys suggest that about one in three mental health professionals will fear for their lives at some point in their professional career (Arthur, Brende, & Quiroz, 2003). In the space between a collaborative therapeutic relationship on the one hand and an overtly dangerous relationship marked by threats of imminent harm on the other, there exists a broad swath of possible enactments between patient and psychologist that can cause substantial distress for the clinician while putting them in a legal and ethical hinterland. The purpose of this study was to (a) document the prevalence and types of stalking, threatening, harassing, and attacking behavior (STHB) experienced by highly trained North American psychologists; (b) examine what differences, if any, exist in the nature and extent of STHB that psychologists practicing in different specialty areas and from different theoretical orientations experience; (c) document the types of risk management responses that these experienced clinicians found most (and least) effective; and (d) examine the personality characteristics of

This article was published Online First June 29, 2015.

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The authors thank all those who participated in this research.

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clients who engage in STHB using a standardized measure of personality.

## Defining Stalking, Threatening, and Harassing Behavior

There is a growing body of international research examining clinicians' experiences of STHB by patients in the United States (Gentile, Asamen, Harmell, & Weathers, 2002; Leavitt, Presskreischer, Maykuth, & Grisso, 2006; Romans, Hays, & White, 1996; Sandberg, McNiel, & Binder, 2002; Tryon, 1986), Australia (Purcell, Powell, & Mullen, 2005), New Zealand (Hughes, Thom, & Dixon, 2007), the United Kingdom (Hudson-Allez, 2002; Jones & Sheridan, 2009; Maclean et al., 2013; McIvor, Potter, & Davies, 2008; Whyte, Penny, Christopherson, Reiss, & Petch, 2011), Ireland (Nwachukwu, Agyapong, Quinlivan, Tobin, & Malone, 2012), Canada (Abrams & Robinson, 2011), and Italy (Galeazzi, Elkins, & Curci, 2005; Mastronardi, Pomilla, Ricci, & D'Argenio, 2013). Although stalking statutes vary across jurisdictions, most definitions share an emphasis on repeated, intentional behavior consisting of nonconsensual communication and threats toward a specific individual that would cause a reasonable person to fear for their safety (Mullen, Pathé, Purcell, & Stuart, 1999). Researchers studying mental health professionals' experiences of being stalked have differed in how many instances should be required to constitute "repeated" harassment. At the lower end, McIvor et al. (2008) defined stalking as "two or more episodes where a psychiatric inpatient initiated inappropriate contact outside the clinical setting that caused the psychiatrist concern" (p. 352)—a definition generally consistent with Britain's Protection from Harassment Act. At the upper end, Purcell et al. (2005) required clinicians to have experienced "multiple intrusions (e.g., at least 10), imposed for a period of 2 weeks or more, that induced fear in the recipient" (p. 538). The latter definition is generally consistent with stalking statutes in the United States and, as a more conservative definition, has been empirically shown to better distinguish protracted stalking from brief intrusiveness (Purcell, Pathé, & Mullen, 2004).

## Prevalence of Stalking of Mental Health Professionals

Along with public figures, mental health professionals appear to be among the occupations at highest risk of being stalked, threatened, or harassed in their line of work (Mullen et al., 2009). This appears to hold equally for male and female mental health providers (McIvor et al., 2008; Romans et al., 1996; Whyte et al., 2011), which is notable given that women appear to be the victim of stalking at rates three times higher than men in the general population (Purcell et al., 2004). The available research suggests that between approximately 3% (Sandberg et al., 2002) and 20% (McIvor et al., 2008; Purcell et al., 2005) of mental health professionals will be stalked at some point in their career, with multiple studies placing lifetime prevalence for stalking victimization around 10% (Galeazzi et al., 2005; Gentile et al., 2002; Leavitt et al., 2006; Maclean et al., 2013; Whyte et al., 2011). Given the general consistency in prevalence estimates across studies, the differences that do emerge generally appear to reflect the impact of different definitions of stalking and differences in base rates of STHB in different clinical settings.

Purcell et al.'s (2005) survey of Australian psychologists ($n$ = 830) was notable in that it was one of the only studies to allow for direct comparisons of stalking victimization rates across psychologists practicing in different specialty areas. While these authors found a 20% lifetime prevalence rate of stalking victimization overall, which was identical to the prevalence of stalking victimization found in a sample of 198 community-based psychiatrists in London (McIvor et al., 2008), they also found that forensic (32%), clinical (24%), and counseling (20%) psychologists were victimized more often than educational (16%), neuropsychological (11%), and organizational psychologists (7%). Research with clinicians practicing in forensic settings tends to support the higher rates of STHB observed by Purcell et al.'s (2005) forensic subsample. For example, Leavitt and colleagues (2006) surveyed forensic evaluators in Massachusetts and found that most had been threatened (65%) and nearly half (49%) had been physically assaulted at some point in their career. Similar victimization rates for threats and physical assault have also been found among forensic mental health workers in the United Kingdom (Jones & Sheridan, 2009). Although Leavitt et al. (2006) found rates of stalking victimization to be 10%—on par with nonforensic clinicians (e.g., Whyte et al., 2011)—they did not specify how stalking was defined in their study. In contrast, Jones and Sheridan (2009), using a fairly typical definition of stalking ("two or more intrusions, occurring over a minimum of two weeks, which induced some level of fear in the respondent"), found that fully 42% of their forensic clinicians had been stalked.

## Characteristics of Those Who Stalk Mental Health Professionals

Considerable research suggests that stalkers differ in several ways from typical offender populations. For example, stalkers tend to be males in their 40s—nearly a decade older than other offenders (Meloy & Gothard, 1995; Meloy et al., 2000). Some research suggests that stalkers are more intelligent and have completed more education than other offenders (Meloy & Gothard, 1995), although this finding has not been consistently replicated (Meloy et al., 2000). Meloy and Gothard (1995) also found that although stalkers did not differ from other offenders in terms of psychopathological features, they did differ in terms of personality pathology. Stalkers are more likely than other offenders to have a personality disorder, but less likely to have antisocial (Meloy & Gothard, 1995) or psychopathic (Storey, Hart, Meloy, & Reavis, 2009) personality disorders. Meloy (2002a) suggests that this distinct pattern of personality pathology is the "product of an attachment disorder that is preoccupied rather than dismissive" (p. 230).

Recent research has begun to focus more specifically on the characteristics of those who engage in STHB toward mental health professionals. Gentile et al. (2002) found that clients who engaged in stalking were likely to be single, to carry diagnoses of a mood or personality disorder, to have a history of childhood relationship disturbances, and to be experiencing significant stress. Galeazzi et al. (2005) found that 38 of 40 stalkers in their sample met criteria for at least one *DSM–IV* disorder; 17 had a psychotic disorder, 4 had a mood disorder, and 14 had a personality disorder. Fully 13 of the 14 diagnosed personality disorders were cluster B disorders, a finding consistent with the general stalking literature (Meloy et al., 2000; Mullen et al., 1999). Sandberg et al. (2002) found that most (75%) of those who engaged in STHB were at least 30 years old, and 35% were 40 or older. However, to our knowledge there

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exists no research that has utilized standardized assessment tools to examine the personality characteristics of those who engage in STHB toward mental health professionals.

## Risk Management of Stalking, Threatening, and Harassing Behavior

Clinicians typically report feeling unprepared for dealing with patients that stalk, threaten, and harass them (Purcell et al., 2005). In an effort to address this, Meloy (1997) offered 10 guidelines for the clinical risk management of stalking, including: "a team approach, personal responsibility for safety, documentation and recording, no initiated contact, protection orders, law enforcement and prosecution, treatment if indicated, segregation and incarceration, periodic violence risk assessment, and the importance of dramatic moments" (p. 174). Several years after these guidelines were offered, researchers began to empirically examine the effectiveness of different risk management responses to STHB (Purcell et al., 2005; Sandberg et al., 2002).

Sandberg et al. (2002) interviewed 17 of the 33 clinicians in their study that endorsed experiencing STHB to discuss the risk management strategies used and the perceived effectiveness of each strategy. The most common and effective strategies included notifying coworkers, directors, and police or security. Several strategies were noted to make the situation worse; 25% indicated that hospitalizing the patient or escorting the client out of the building made the STHB worse, as did 17% who confronted the client directly and asked them to stop. Purcell et al. (2005) found that most (71%) of the psychologists who had experienced STHB made changes to their professional and personal lives. Changes included changing telephone numbers, increasing security at work and at home, and moving. Nearly one in five (19%) missed work as a result of the STHB and 10% altered their social life. Nearly every (95%) psychologist who experienced STHB talked with coworkers, family, and friends about how to manage it. One in four (25%) reported it to the police and nearly one in five consulted a lawyer (19%) or sought help from a health professional (18%).

## The Present Study

Although there is now a substantial body of peer-reviewed research examining clinicians' experiences of patients' STHB, a majority of this research has one or more methodological features that might limit the generalizability of the findings to North American psychologists practicing across a range of settings. For example, only a small proportion of the extant literature focuses exclusively on psychologists (Gentile et al., 2002; Purcell et al., 2005; Tryon, 1986). Most include samples of psychiatrists only (Maclean et al., 2013; Mastronardi et al., 2013; Nwachukwu et al., 2012), mixtures of professionals from different mental health disciplines (e.g., psychologists, social workers, psychiatrists: Arthur et al., 2003; Hudson-Allez, 2002; Hughes et al., 2007), or professionals from different health care disciplines (e.g., psychologists, nurses, physicians: Abrams & Robinson, 2011; Romans et al., 1996; Sandberg et al., 2002). Even within this variegated landscape, only a small minority of these data were collected from North American clinicians (Gentile et al., 2002; Romans et al., 1996; Sandberg et al., 2002; Tryon, 1986). To our knowledge, Gentile et al.'s (2002) survey, now more than a decade old, reflects the only data on stalking victimization from a national sample exclusively comprising North American psychologists. Although there has been a resurgence of research examining mental health provider's experiences of STHB in the last several years (Maclean et al., 2013; Mastronardi et al., 2013; McIvor et al., 2008; Nwachukwu et al., 2012; Whyte et al., 2011), nearly all of these studies have focused on Western European psychiatrists practicing in distinct health systems from their North American counterparts. Given this, practicing North American psychologists are currently left to balance the clinical relevance of more contemporary research derived from samples of uncertain generalizability with the limited and less contemporary research with North American psychologists.

Several findings in the decade-plus following Gentile et al.'s (2002) North American survey further highlight the need for additional research. For example, Galeazzi et al. (2005) found that clinicians' age and/or experience might decrease the risk of being stalked by a patient; Purcell et al. (2005) showed that clinicians' area of practice as well as the perceived motivations of those who stalk psychologists is relevant to patients' overall risk for subsequent violence; and an empirically derived operational definition for stalking that optimally distinguishes brief intrusions from prolonged stalking episodes has been identified (Purcell et al., 2004).

The present study attempts to incorporate these developments by surveying highly trained and experienced North American psychologists board certified by the American Board of Professional Psychology. A national sample of board-certified psychologists practicing in a range of practice settings and across a range of specialty practice areas was surveyed about their experiences with clients' STHB. Drawing on Purcell et al.'s (2005) Stalking Victimization Survey Project, an empirically derived definition of stalking was employed, defined as 10 or more intrusions over a period of two weeks or longer that resulted in fear. Psychologists were also asked to describe patients' motivations for engaging in STHB toward them and to complete a standardized, clinician-rated personality measure about the most recent patient to engage in STHB. Finally, psychologists described the nature and perceived success of their risk management responses and any changes to their practice as a result of this experience.

# Method

## Participants

Participants included 157 (48.4% male) licensed psychologists board certified by the American Board of Professional Psychology (ABPP). Participants had been licensed to practice psychology for an average of 21.79 years ($SD = 12.52$). Fewer than half (45.9%) were 55 or younger and nearly one quarter (22.3%) of the sample was more than 65 years old. The ABPP specialty boards with the most respondents included clinical (33.8%; $n = 53$), clinical neuropsychology (21.7%; $n = 34$), and forensic (13.4%; $n = 21$; see Table 1). More than half (53.5%) of the sample indicated they spent at least some of their professional time devoted to forensic activities. Those engaging in forensic activities devoted generally similar proportions of their professional time to family ($M = 20.54$, $SD = 31.46$), criminal ($M = 29.12$, $SD = 36.99$), civil ($M = 29.42$, $SD = 35.53$), and "other" (36.41, $SD = 32.75$) areas of forensic work.

Table 1
*Characteristics of Board Certified Psychologists Stalked, Threatened, Harassed, and Attacked by Patients*

| Characteristic | Overall sample | | Stalked[a] | | Stalked/ Harassed | | Threatened | | Attacked | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | *n* | % | *n* | % | *n* | % | *n* | % | *n* |
| Total | 100 | 157 | 14.0 | 22 | 71.3 | 112 | 21.0 | 33 | 2.5 | 4 |
| Gender[b] | | | | | | | | | | |
| Women | 48.4 | 76 | 14.5 | 11 | 72.4 | 55 | 14.5 | 11 | 0.0 | 0 |
| Men | 48.4 | 76 | 13.2 | 10 | 73.7 | 56 | 27.6 | 21 | 5.3 | 4 |
| Age | | | | | | | | | | |
| 25–35 | 7.6 | 12 | 0.0 | 0 | 50.0 | 6 | 8.3 | 1 | 0.0 | 0 |
| 36–45 | 21.7 | 34 | 5.9 | 2 | 76.5 | 26 | 14.7 | 5 | 0.0 | 0 |
| 46–55 | 16.6 | 26 | 15.4 | 4 | 76.9 | 20 | 23.1 | 6 | 0.0 | 0 |
| 56–65 | 29.3 | 46 | 21.7 | 10 | 76.1 | 35 | 23.9 | 11 | 4.3 | 2 |
| 65 | 22.3 | 35 | 17.1 | 6 | 71.4 | 25 | 28.6 | 10 | 5.7 | 2 |
| ABPP Specialty[c] | | | | | | | | | | |
| Clinical | 33.8 | 53 | 15.1 | 8 | 67.9 | 36 | 22.6 | 12 | 7.5 | 4 |
| Forensic | 13.4 | 21 | 23.8 | 5 | 81.0 | 17 | 23.8 | 5 | 4.8 | 1 |
| Child & Adolescent | 3.8 | 6 | 0.0 | 0 | 33.3 | 2 | 16.7 | 1 | 0.0 | 0 |
| Health | 5.1 | 8 | 0.0 | 0 | 62.5 | 5 | 25.0 | 2 | 0.0 | 0 |
| Neuropsychology | 21.7 | 34 | 14.7 | 5 | 85.3 | 29 | 20.6 | 7 | 0.0 | 0 |
| Cognitive & Behavioral | 5.1 | 8 | 0.0 | 0 | 37.5 | 3 | 0.0 | 0 | 0.0 | 0 |
| Counseling | 7.6 | 12 | 25.0 | 3 | 83.3 | 10 | 25.0 | 3 | 0.0 | 0 |
| Couple & Family | 3.8 | 6 | 16.7 | 1 | 100 | 6 | 16.7 | 1 | 0.0 | 0 |
| Organization & Business | 1.9 | 3 | 33.3 | 1 | 66.7 | 2 | 33.3 | 1 | 0.0 | 0 |
| Police & Public Safety | 1.3 | 2 | 0.0 | 0 | 100.0 | 2 | 50.0 | 1 | 0.0 | 0 |
| Psychoanalysis | 0.6 | 1 | 0.0 | 0 | 100.0 | 1 | 100 | 1 | 0.0 | 0 |
| Rehabilitation | 3.2 | 5 | 20.0 | 1 | 80.0 | 4 | 60.0 | 3 | 0.0 | 0 |
| School | 2.5 | 4 | 0.0 | 0 | 50.0 | 2 | 0.0 | 0 | 0.0 | 0 |
| Theoretical orientation | | | | | | | | | | |
| Cognitive–Behavioral | 47.8 | 75 | 9.3 | 7 | 66.7 | 50 | 16.0 | 12 | 0.0 | 0 |
| Psychodynamic/Analytic | 13.4 | 21 | 23.8 | 5 | 76.2 | 16 | 33.3 | 7 | 9.5 | 2 |
| Humanistic/Existential | 2.5 | 4 | 0.0 | 0 | 100.0 | 4 | 50.0 | 2 | 0.0 | 0 |
| Family Systems | 3.8 | 6 | 50.0 | 3 | 83.3 | 5 | 16.7 | 1 | 0.0 | 0 |
| Integrative/Eclectic | 20.4 | 32 | 18.8 | 6 | 84.4 | 27 | 28.1 | 9 | 6.3 | 2 |
| Other | 6.4 | 10 | 10.0 | 1 | 80.0 | 8 | 10.0 | 1 | 0.0 | 0 |
| Proportion professional time devoted to psychotherapy | | | | | | | | | | |
| 0% | 23.6 | 37 | 8.1 | 3 | 75.7 | 28 | 16.2 | 6 | 0.0 | 0 |
| 1–20% | 25.5 | 40 | 17.5 | 7 | 80.0 | 32 | 25.0 | 10 | 2.5 | 1 |
| 21–40% | 10.8 | 17 | 5.9 | 1 | 47.1 | 8 | 11.8 | 2 | 0.0 | 0 |
| 41–60% | 12.1 | 19 | 21.1 | 4 | 78.9 | 15 | 36.8 | 7 | 0.0 | 0 |
| 61–80% | 12.1 | 19 | 5.3 | 1 | 68.4 | 13 | 15.8 | 3 | 0.0 | 0 |
| 81–100% | 13.4 | 21 | 28.6 | 6 | 76.2 | 16 | 23.8 | 5 | 14.3 | 3 |
| Proportion professional time devoted to forensic evaluation | | | | | | | | | | |
| None (0%) | 42.7 | 67 | 9.0 | 6 | 64.2 | 43 | 13.4 | 9 | 1.5 | 1 |
| Some (>0%) | 53.5 | 84 | 17.9 | 15 | 81.0 | 68 | 28.6 | 24 | 3.6 | 3 |
| 1–20% | 29.3 | 46 | 19.6 | 9 | 89.1 | 41 | 32.6 | 15 | 4.3 | 2 |
| 21–40% | 5.1 | 8 | 25.0 | 2 | 75.0 | 6 | 25.0 | 2 | 0.0 | 0 |
| 41–60% | 5.1 | 8 | 0.0 | 0 | 62.5 | 5 | 25.0 | 2 | 0.0 | 0 |
| 61–80% | 2.5 | 4 | 0.0 | 0 | 75.0 | 3 | 25.0 | 1 | 0.0 | 0 |
| 81–100% | 11.5 | 18 | 22.2 | 4 | 72.2 | 13 | 22.2 | 4 | 5.6 | 1 |
| Areas of forensic practice | | | | | | | | | | |
| Family | 24.2 | 38 | 23.7 | 9 | 81.6 | 31 | 36.8 | 14 | 7.9 | 3 |
| Criminal | 30.6 | 48 | 18.8 | 9 | 79.2 | 38 | 31.3 | 15 | 6.3 | 3 |
| Civil | 36.3 | 57 | 19.3 | 11 | 86.0 | 49 | 31.6 | 18 | 3.5 | 2 |
| Other | 17.2 | 27 | 29.6 | 8 | 88.9 | 24 | 25.9 | 7 | 0.0 | 0 |

[a] Stalking is defined as experiencing 10 or more intrusions over a period of 2 weeks or longer that result in fear. [b] When percentages do not sum to 100% it is attributable to missing/incomplete data. [c] When percentages exceed 100% it is attributable to overlap between groups (e.g., clinicians holding multiple board certifications).

Participants endorsed a variety of primary theoretical orientations, including cognitive–behavioral (47.8%; $n = 75$), integrative/eclectic (20.4%; $n = 32$), psychodynamic/ psychoanalytic (13.4%; $n = 21$), family systems (3.8%; $n = 6$), humanistic/ existential (2.5%; $n = 4$), and "other" (6.4%; $n = 10$).

## Procedures

All psychologists holding board certification status with the American Board of Professional Psychology were eligible for participation. Participant e-mail addresses were obtained through

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the American Board of Professional Psychology's online directory. Eligible psychologists were emailed an invitation to participate that included a link to an online survey questionnaire through an encrypted web site. Participants were sent one follow-up e-mail an average of seven days after the initial study invitation was sent. All participants who completed the survey were eligible to be entered into a drawing to win one of five $20 Amazon gift cards.

### Measures

**Demographics and professional background.** Demographic information was collected regarding age, primary area of practice, theoretical orientation, board-certification status, and proportion of professional time devoted to forensic activities and areas of forensic practice (e.g., family, criminal, civil).

**STHB questionnaire.** The Stalking Victimization Survey Project developed by Purcell et al. (2005) was utilized to assess psychologists' experiences with unwanted intrusions by clients. All participants were asked whether a client had ever: "(a) followed them; (b) kept them under surveillance; (c) loitered around their workplace, home, or other places they frequent; (d) made unwanted approaches; (e) made unsolicited telephone calls; (f) sent unwanted letters, faxes, or e-mail; (g) sent offensive materials; or (h) interfered with their property" (Purcell et al., 2005, p. 538). Participants who denied experiencing any of these eight types of intrusive behavior were thanked for their time and received no further questions. Respondents who endorsed any of these items were presented with follow-up questions regarding the frequency and persistence of each of the unwanted intrusions they endorsed, whether it caused them fear, whether they were ever threatened or physically attacked, and the risk management responses and the perceived effectiveness for each response endorsed. In addition to allowing for comparability with previous research, questions from Purcell et al.'s (2005) survey were utilized because they allow for a behaviorally based definition of stalking victimization that is consistent with antistalking legislation in the United States.

**Shedler-Westen Assessment Procedure-Prototype (SWAP-P) Scoring (Westen, Shedler, & Bradley, 2006).** The SWAP-P is derived from the Shedler-Westen Assessment Procedure-II (SWAP: Shedler & Westen, 2007), a 200-item clinician scored Q-sort. The SWAP-P provides empirically derived prototypical descriptors in a single paragraph format for each of 10 personality disorders and asks respondents to rate the extent to which their patient matches this prototype on a 1 (*No match; description does not apply*) to 5 (*Very good match; patient exemplifies this disorder; prototypical case*) scale. Scores of 4 and 5 both indicate that the patient meets diagnostic criteria for this disorder, allowing the SWAP-P to provide dimensional as well as categorical data for each personality disorder. Personality disorders are organized under four hierarchical categories derived from Q factor analysis (Westen & Shedler, 2007), including the *Internalizing Spectrum* (Depressive, Anxious–Avoidant, Dependent-Victimized, and Schizoid–Schizotypal Personalities), *Externalizing Spectrum* (Antisocial–Psychopathic, Paranoid, and Narcissistic Personalities), *Borderline–Dysregulated Spectrum* (Borderline–Dysregulated Personality), and *Neurotic Styles* (Obsessional and Hysteric–Histrionic Personalities). Research supports the interrater reliability and validity of the SWAP-P (Westen et al., 2012; Westen et al., 2006) and indicates that the SWAP-P appears to minimize diagnostic comorbidity without a loss of validity relative to DSM's polythetic approach (Westen et al., 2006). Further, given that observer reports tend to more accurately predict externalizing behavior whereas self-reports better predict internalizing outcomes, the use of a clinician-rated instrument such as the SWAP-P was thought to be optimal for the present study given its emphasis on problematic externalizing behavior.

## Results

As shown in Table 1, 71% ($n = 112$) of the psychologists in the present sample endorsed having been, at a minimum, harassed by clients at some point in their professional careers, while nearly one in seven (14.0%; $n = 22$) met criteria for having been stalked. Slightly more than one in five psychologists (21.0%; $n = 33$) had been threatened but only 2.5% ($n = 4$) had been physically attacked. Twice as many psychologists (5.1%; $n = 8$) had their property damaged than were physically attacked. Property damage included having clients break holes in their walls, destroying office artwork, breaking windows, breaking the psychologist's eyeglasses, and uprooting a ficus tree, among other incidents. No gender differences emerged among psychologists who were stalked, $\chi^2(1, N = 151) = .07$, $p = .79$, or harassed, $\chi^2(1, N = 148) = .23$, $p = .64$. However, there were significant differences across genders for being threatened, $\chi^2(1, N = 103) = 4.82$, $p = .03$, and attacked, $\chi^2(1, N = 103) = 4.24$, $p = .04$, such that men were more likely to be threatened (27.6% vs. 14.5%) and attacked (5.3% vs. 0.0%) than women.

There was a trend approaching significance indicating that lifetime rates of stalking victimization differed among clinicians from different theoretical orientations, $\chi^2(5, N = 147) = 10.1$, $p = .07$. Psychologists endorsing a psychodynamic/psychoanalytic (23.8%), family systems (50.0%), and integrative/eclectic (18.8%) orientation reported higher rates of stalking victimization than those endorsing a cognitive–behavioral (9.3%), humanistic/existential (0%), and "other" (10.0%) orientation. However, differences in victimization based on theoretical orientation were limited to stalking, as no differences emerged for being harassed, $\chi^2(5, N = 146) = 4.89$, $p = .43$, threatened, $\chi^2(5, N = 102) = 4.87$, $p = .43$, or attacked, $\chi^2(5, N = 102) = 7.5$, $p = .19$.

Psychologists who engaged in some forensic practice were nearly twice as likely to be stalked than psychologists who did not engage in any forensic practice (17.9% vs. 9.0%). This difference revealed a modest but nonsignificant trend for those who engaged in some forensic practice to experience higher rates of stalking victimization than those who did not engage in any forensic practice, $\chi^2(1, N = 150) = 2.4$, $p = .13$. A similar trend approaching significance emerged suggesting that those who engaged in some forensic practice were more likely to have been threatened by a client than psychologists who did not engage in any forensic practice (28.6% vs. 13.4%), $\chi^2(1, N = 103) = 3.18$, $p = .07$. Finally, although psychologists who engaged in forensic work were significantly more likely to be harassed than psychologists not engaging in any forensic practice (81.0% vs. 64.2%), $\chi^2(1, N = 148) = 6.16$, $p = .01$, they were no more likely to be physically attacked (3.6% vs. 1.5%), $\chi^2(1, N = 103) = .38$, $p = .54$.

Most psychologists who had been harassed (85.5%; $n = 89$) or stalked (95.5%; $n = 21$) reported that they could infer a motivation

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for their client's intrusive behavior. Resentment was the most common motivation for those who harassed (29.3%; $n = 46$) or stalked (45.5%; $n = 10$). When infatuation was the motivation, clients were more likely to engage in stalking (22.7%; $n = 5$) than harassment (10.2%; $n = 16$). Further, compared to clients whose STHB was motivated by resentment, those motivated by infatuation persisted for significantly longer, $t(56) = 2.27$, $p < .05$. Clients motivated by resentment persisted for an average of 31.38 weeks ($SD = 70.33$), whereas those motivated by infatuation persisted for an average of 151.95 weeks ($SD = 329.74$). Resentful clients were more likely than infatuated clients to threaten psychologists, $\chi^2(1, N = 61) = 4.4$, $p < .05$, but were no more likely to physically attack, $\chi^2(1, N = 61) = 0.6$, $p = .44$.

Although threats were relatively common, such threats were only moderately associated with physical attacks, $r = .29$, $p < .01$. Specifically, whereas more than one in five (21%, $n = 33$) psychologists had been threatened, only a small portion (12.1%; $n = 4$) of this group was attacked – 87.9% ($n = 29$) of threatened psychologists were not physically attacked. However, of those who were physically attacked, all (100%, $n = 4$) had previously been threatened. Further, among the few who were physically attacked, fully 50% ($n = 2$) had also previously been stalked by their attacker. Specific to the psychologists who were stalked, 54.5% ($n = 12$) had been threatened and 9.1% ($n = 2$) were physically attacked.

## Risk Management Responses

Most psychologists (60.2%) indicated that they did not feel prepared by their training for dealing with experiences of STHB. Table 2 shows the risk management responses of psychologists across different types of STHB victimization experiences. Overall, results indicate that a sizable minority of psychologists had experienced adverse outcomes for several clinical risk management responses. For example, referring clients elsewhere appeared to make the situation worse nearly as often as it made the situation better. Directly confronting the client or having the client hospitalized was also described as making the situation worse by a substantial minority of psychologists. In general, legal interventions such as having the client arrested and obtaining a restraining order were rated as making the situation better. One exception to this was that one in five psychologists who were being stalked reported that seeking assistance from the police made the situation worse. Nearly all psychologists experiencing STHB sought assistance from work colleagues and friends, and this was almost always viewed as helpful. Most stalked (63.6%; $n = 14$) and threatened (54.5%; $n = 18$) psychologists sought assistance from an attorney, and all reported that this was either beneficial or had no effect. Relatively few psychologists who experienced STHB made changes to their personal or professional life with two exceptions—a substantial minority increased their home and workplace security. These changes were considered to make the situation better in 30% to 60% of these cases.

## Patient Characteristics

Patients who stalked were, on average, 25.36 ($SD = 9.04$) years old when the stalking commenced and more than half (59.1%; $n = 13$) were female. The age of the stalkers did not vary by gender, $t(20) = .06$, $p = .95$. Clients who stalked persisted for an average of 61.55 weeks ($SD = 89.37$), with a range of 2 to 416 weeks. The most common type of professional relationship for patients who stalked was outpatient psychotherapy patient (36.4%; $n = 8$), followed by outpatient forensic evaluee (18.2%; $n = 4$), outpatient clinical evaluee (13.6%; $n = 3$), and inpatient psychotherapy patient (4.5%; $n = 1$). About a quarter (27.3%; $n = 6$) of all patients who engaged in stalking were defined as having an "other" professional relationship. Most patients (77.3%; $n = 17$) who stalked were described as mentally ill at the time of the stalking. Psychiatric diagnoses included psychotic (4.5%; $n = 1$), mood (13.6%; $n = 3$), anxiety (13.6%; $n = 3$), dissociative (9.1%; $n = 2$), and neurological disorders (13.6%; $n = 3$).

Table 3 provides data regarding the personality characteristics of clients who engage in STHB as assessed by the SWAP-P and reveals high rates of personality pathology among these individuals. A majority (60.7%; $n = 68$) were rated as meeting diagnostic criteria for at least one personality disorder. Examining the four higher-order spectrums (internalizing, externalizing, borderline/dysregulated, and neurotic) of personality disorder identified by Westen et al. (2012), it appears that STHB perpetrators were diagnosed on the neurotic spectrum at roughly one third the rate of the borderline/dysregulated, externalizing, and internalizing spectrums. At the level of specific diagnosis, clients engaging in STHB were coded as meeting criteria for borderline/dysregulated personality disorder (28.6%; $n = 32$) far more frequently than any other diagnosis. Paranoid personality disorder (17.9%; $n = 20$) was the second most frequent diagnosis, followed by narcissistic (13.4%; $n = 15$) and dependent–victimized (13.4%; $n = 15$) personality disorders.

# Discussion

## General Conclusions and Implications

The present study has several implications for practicing psychologists. First, these findings highlight the need for more readily available clinical risk management training for practicing psychologists. Although previous research has documented the general feeling of unpreparedness among clinicians for dealing with clients' STHB, this study was the first to show that even a majority of highly trained psychologists deemed to possess a specialized level of clinical knowledge and skill endorsed feeling similarly unprepared. The pervasiveness of the problem—evident in the fact that nearly three in four psychologists in this sample were harassed at some point in their career, over one in five threatened, and about one in seven stalked—further highlights the need for improved clinical risk management training opportunities for practicing psychologists.

Although we believe that clinical risk management education should be integrated into general clinical training, our findings do suggest that psychologists practicing in certain specialty areas and from certain theoretical orientations might be at a relatively higher risk of experiencing at least some forms of STHB. For example, forensic psychologists were about twice as likely to be stalked and threatened than those who did not engage in any forensic activities. Similarly, psychologists practicing from certain theoretical orientations, such as psychodynamic, appear to experience higher rates of stalking by their clients than psychologists practicing from other

Table 2
*Risk Management Responses*

| Response | Harassed/Stalked ($N = 112$) | | Stalked ($N = 22$) | | Threatened ($N = 33$) | |
|---|---|---|---|---|---|---|
| | %[a] | *N* | % | *N* | % | *N* |
| Clinical risk management responses | | | | | | |
| Confront client directly | 51.8 | 58 | 59.1 | 13 | 60.6 | 20 |
| Made better[b] | 46.6 | 27 | 53.8 | 7 | 30.0 | 6 |
| Made worse[c] | 13.8 | 8 | 15.4 | 2 | 25.0 | 5 |
| Refer client elsewhere for services | 33.9 | 38 | 54.5 | 12 | 36.4 | 12 |
| Made better | 39.5 | 15 | 33.3 | 4 | 33.3 | 4 |
| Made worse | 15.8 | 6 | 33.3 | 4 | 33.3 | 4 |
| Have client hospitalized | 10.7 | 12 | 22.7 | 5 | 18.2 | 6 |
| Made better | 16.7 | 2 | 0.2 | 1 | 16.7 | 1 |
| Made worse | 16.7 | 2 | 0.2 | 1 | 33.3 | 2 |
| Have client arrested | 4.5 | 5 | 4.5 | 1 | 9.1 | 3 |
| Made better | 60.0 | 3 | — | 0 | 66.7 | 2 |
| Made worse | 0.0 | 0 | — | 0 | 0.0 | 0 |
| Obtain restraining order against client | 6.3 | 7 | 18.2 | 4 | 6.1 | 2 |
| Made better | 71.4 | 5 | 50.0 | 2 | 100 | 2 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Changes to personal/professional life | | | | | | |
| Increase workplace security | 31.3 | 35 | 50.0 | 11 | 45.5 | 15 |
| Made better | 60.0 | 21 | 45.5 | 5 | 46.7 | 7 |
| Made worse | 2.9 | 1 | 9.1 | 1 | 0.0 | 0 |
| Increase home security | 17.0 | 19 | 45.5 | 10 | 30.3 | 10 |
| Made better | 47.4 | 9 | 40.0 | 4 | 30.0 | 3 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Change home telephone number | 3.6 | 4 | 4.5 | 1 | 6.1 | 2 |
| Made better | 50.0 | 2 | 100 | 1 | 50.0 | 1 |
| Made worse | 25.0 | 1 | 0.0 | 0 | 0.0 | 0 |
| Change work telephone number | 0.9 | 1 | 0.0 | 0 | 3.0 | 1 |
| Made better | 100 | 1 | — | — | 100 | 1 |
| Made worse | 0.0 | 0 | — | — | 0.0 | 0 |
| Change work address/relocate | 0.9 | 1 | 4.5 | 1 | 0.0 | 0 |
| Made better | 100 | 1 | 100 | 1 | — | — |
| Made worse | 0.0 | 0 | 0.0 | 0 | — | — |
| Change home address | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Made better | 0.0 | 0 | — | — | — | — |
| Made worse | 0.0 | 0 | — | — | — | — |
| Reduce social outings | 3.6 | 4 | 4.5 | 1 | 3.0 | 1 |
| Made better | 25.0 | 1 | 0.0 | 0 | 0.0 | 0 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Assistance sought from: | | | | | | |
| Family or friends | 33.0 | 37 | 45.5 | 10 | 54.5 | 18 |
| Made better | 64.9 | 24 | 90.0 | 9 | 77.8 | 14 |
| Made worse | 2.7 | 1 | 0.0 | 0 | 0.0 | 0 |
| Work colleagues/superiors | 69.6 | 78 | 86.4 | 19 | 90.9 | 30 |
| Made better | 60.3 | 47 | 73.7 | 14 | 66.7 | 20 |
| Made worse | 2.6 | 2 | 5.3 | 1 | 6.7 | 2 |
| Police | 20.5 | 23 | 45.5 | 10 | 33.3 | 11 |
| Made better | 65.2 | 15 | 60.0 | 6 | 72.7 | 8 |
| Made worse | 8.7 | 2 | 20.0 | 2 | 9.1 | 1 |
| Lawyer | 25.9 | 29 | 63.6 | 14 | 54.5 | 18 |
| Made better | 58.6 | 17 | 50.0 | 7 | 77.8 | 14 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Psychotherapist | 9.8 | 11 | 18.2 | 4 | 15.2 | 5 |
| Made better | 45.5 | 5 | 50.0 | 2 | 60.0 | 3 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Professional indemnity provider | 17.0 | 19 | 36.4 | 8 | 36.4 | 12 |
| Made better | 42.1 | 8 | 50.0 | 4 | 50.0 | 6 |
| Made worse | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |

*Note.* Perceived effectiveness is based on a 1–5 scale with higher numbers indicating greater effectiveness and scores less than 3 indicating that the intervention made the situation worse. The scale is as follows: (1) *it made things much worse*, (2) *it made things somewhat worse*, (3) *no impact*, (4) *it made things somewhat better*, and (5) *it made things much better*.
[a] Percentages based on those endorsing having experienced any STHB; other column percentages reflect the proportion of respondents endorsing those specific forms of STHB. [b] Made better is defined as responses of 4 (*it made things somewhat better*) or 5 (*it made things much better*). [c] Made worse is defined as responses of 1 (*it made things much worse*) or 2 (*it made things somewhat worse*).

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Table 3
*Personality Disorders Among Clients Who Engage in STHB*

| Disorder | % | *n* |
|---|---|---|
| Any SWAP-P diagnosis[a] | 60.7 | 68 |
| Internalizing spectrum | 23.2 | 26 |
| Depressive PD | 10.7 | 12 |
| Anxious–Avoidant PD | 5.4 | 6 |
| Dependent–Victimized PD | 13.4 | 15 |
| Schizoid–Schizotypal PD | 7.1 | 8 |
| Externalizing spectrum | 32.1 | 36 |
| Antisocial–Psychopathic PD | 10.7 | 12 |
| Paranoid PD | 17.9 | 20 |
| Narcissistic PD | 13.4 | 15 |
| Borderline/dysregulated spectrum | — | — |
| Borderline-Dysregulated PD | 28.6 | 32 |
| Neurotic styles | 9.8 | 11 |
| Obsessional PD | 2.7 | 3 |
| Hysteric-Histrionic PD | 8.0 | 9 |

[a] Diagnosis was established by ratings of 4 (*Good match; patient* has *this disorder; diagnosis applied*) or 5 (*Very good match; patient* exemplifies *this disorder; prototypical case*) for each diagnostic prototype.

theoretical orientations, such as cognitive–behavioral. Interestingly, the differences in STHB victimization experiences between cognitive–behavioral and psychodynamic psychologists were limited *only* to stalking. Although the data cannot provide clear answers to why this might be, these findings raise intriguing questions about the overlapping role of transference and fantasy in both psychodynamic psychotherapy as well as stalking. Meloy's (2002b) psychodynamic model of stalking is predicated on the development of a narcissistic linking fantasy. Given the relatively limited structure that fosters the development of transference in psychodynamic therapy (Ablon & Jones, 1998), it is possible that such approaches might sometimes foster the narcissistic linking fantasies essential to stalking. In other words, the stalking of mental health professionals might, in certain situations, reflect fantasy-driven transference run amok. The relatively lower rates of stalking observed among cognitive–behavioral psychologists might then be understood to reflect the transference-minimizing effects of more structured therapeutic approaches.

Second, related to the specific aspects of risk management that psychologists might particularly benefit from, our data indicate that psychologists generally are able to seek assistance from a range of individuals and alter some aspects of their personal and professional lives to good effect. In contrast, clinical aspects specific to how psychologists respond directly to the patient engaging in STHB highlights some areas for improvement. For example, although few risk management responses overall were rated as making the situation worse, these harmful items were overrepresented among the clinical risk management responses. Confronting the client directly, referring them elsewhere for services, and having them hospitalized were all found to have made the situation worse in a substantial minority of our cases. These findings, which are consistent with Sandberg et al. (2002), suggest that psychologists should be cautious in using these strategies with clients engaging in STHB. It is also noteworthy that the items rated as making the situation worse were more commonly clinical items, whereas involving the legal system in various ways (e.g., obtaining a restraining order, having the client arrested, seeking assistance from an attorney) appears less likely to make the situation worse. This suggests that psychologists faced with a client engaging in STHB should remember that there is a time for clinical intervention and a time to involve the criminal justice system, but persisting with clinical interventions beyond their "sell by" date can prove detrimental in some cases.

Third, these findings provide a nuanced picture regarding psychologists' risk for being physically attacked in the context of clients' STHB. Overall, only about 1 in 50 psychologists had been physically attacked. Threats emerged as a sensitive but highly nonspecific risk factor for being physically attacked. None of the physical attacks reported occurred without warning—all were preceded by a threat. However, only a very small proportion of threats lead to violence. That threats are, at best, weakly predictive of overt physical violence requires psychologists to consider a broader range of factors in evaluating risk for physical violence.

Finally, our results document very high rates of personality disorders among clients who engage in STHB. The implication of this finding brings our discussion full circle. Specifically, given that individuals with personality disorders often require intensive, long-term psychotherapy, readers might note that such treatment is, in and of itself, a potential petri dish for STHB. As a result, psychologists at all levels of experience might benefit from risk management training to feel more prepared for managing the risks inherent in treating this challenging population should they find themselves managing a patient engaging in STHB.

Future research will be necessary to address three primary limitations of the present study. First, although this is among the first studies to examine the perceived effectiveness of a wide range of risk management responses, the present data cannot answer several important questions. For one, it is possible that clinicians had different notions of what constituted an "effective" intervention and might reasonably include interventions seen to result in a cessation of STHB, an increased sense of personal safety, or positive therapeutic outcomes, among other possibilities. Future research will benefit from distinguishing such outcomes to better understand the link between risk management responses and specific results. Second, because stalking is a process rather than an event, most clinicians use multiple risk management strategies over time. Although the present study is not able to address issues of timing and sequencing of risk management responses, such considerations will be essential to better understand how clinicians' responses play out in clinical practice. Finally, although the present study was the first to use a standardized personality measure, it is a methodological limitation that participants provided both the personality ratings and the STHB outcomes. Although the conflation of SWAP ratings and outcomes has been a general challenge for SWAP research (Wood, Garb, Nezworski, & Koren, 2007), we believe that the fact that most of our outcomes were behaviorally based and required minimal inference minimized the effects of this methodological limitation.

## Recommendations for Practice

As noted previously, between a positive therapeutic alliance and an overtly threatening dynamic there exist a broad range of enactments that can occur between patient and therapist. Table 4 provides seven general recommendations for clinicians who find themselves working with patients who engage in STHB. The first

Table 4
*STHB Risk Management Recommendations*

| |
|---|
| 1. Proactive risk management planning |
| 2. Ongoing assessment of risk and protective factors |
| 3. Consultation |
| 4. Crisis therapy approach with enhanced structure |
| 5. Triangulate third parties into clinical dyad |
| 6. Discontinue all contact |
| 7. Criminal justice intervention |

four steps are broadly applicable to most cases of STHB, whereas steps five through seven reflect escalated responses that are recommended specifically for cases in which either prior efforts were ineffective or deemed inappropriate given the severity of the situation. First, sound risk management practice requires proactive risk management planning, and clinicians and the organizations in which they practice should anticipate that they will be confronted with STHB. Second, when patients are identified as engaging in problematic intrusive behavior, a detailed assessment of dynamic risk (see Otto, 2000, for review) and protective (see de Vries Robbé, de Vogel, & Douglas, 2013, for review) factors should be carried out. Third, if it is determined that ongoing therapeutic contact is appropriate, clinicians should establish an ongoing consultative relationship to assist the risk management process. Fourth, along with establishing a consultative relationship, clinicians should also transition to a crisis management approach to treatment characterized by enhanced structure and clear boundaries. Risk assessment should be an ongoing process, and both consultation and a crisis management approach should be maintained until the level of risk is judged to be acceptable to return to prior therapeutic work. Fifth, if these steps prove inadequate or inappropriate given the initial level of risk, it is recommended that clinicians triangulate third parties into the clinical dyad in an effort to diffuse the patient's affect and interrupt any fantasies that might be fueling the STHB. Sixth, if ongoing contact is determined to present an unacceptable level of risk, all contact should be discontinued and administrative staff should handle all correspondence. Clinicians should be mindful of the strength of intermittent reinforcement schedules and be disciplined in resisting the patient's attempts at reestablishing contact. Finally, in some situations, it is advisable to proceed to step seven and to involve law enforcement. As Meloy (1997) noted, "Stalking is bad (antisocial) behavior done by mad (angry or psychotic, or both) people" (p. 181) and appropriate intervention should include "*both* social condemnation and humane psychiatric and psychological treatment." It is our hope that these recommendations will stimulate consideration and aid clinicians in planning for and responding effectively and efficiently to patients who engage in STHB. In the words of Ralph Waldo Emerson, "In skating over thin ice our safety is in our speed."

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Received November 4, 2014
Revision received April 30, 2015
Accepted May 3, 2015 ■

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