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## Management and Treatment of Stalkers: Problems, Options, and Solutions

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**Legal sanctions alone are often ineffective in preventing stalking because, in the absence of treatment, the fundamental problems driving the stalker remain unresolved. Criminal justice interventions can be problematic because of difficulties in framing anti-stalking legislation and inconsistencies in their application. Civil remedies in the form of restraining orders may be ineffective or counterproductive. Treatment of stalkers involves pharmacotherapy when mental illness is present, but the mainstays of treatment for non-psychotic stalkers are programmes of psychological intervention. These depend on accurate assessment of the risks inherent in stalking and on the identification of psychological deficits, needs, and responsivity factors specific to the individual. Treatment can then be tailored to suit the stalker, thereby enhancing therapeutic efficacy. Developing a framework for identifying the risk factors and shaping the delivery of treatment is crucial. Two service innovations developed specifically to work with stalkers are presented as options to overcome current management deficiencies. Copyright © 2011 John Wiley & Sons, Ltd.**

Stalking is a problematic and damaging behavior which affects at least 8% of women and 2% of men at some stage of their lives (Tjaden & Thoennes, 1998) with some estimates being considerably higher (Dressing, Kuehner & Gass, 2005; Purcell, Pathé & Mullen, 2002). The harm that it causes has been increasingly recognized in Western countries over the past 20 years, amongst the public and in legal and clinical circles. This has been reflected in increased media attention, the spread of anti-stalking legislation and the expansion of dedicated research, and in the increasing number of stalkers coming before the courts or being recognized by mental health professionals (Mullen, Pathé & Purcell, 2009).

Stalking is a complex, heterogeneous phenomenon that varies in form, motivation, impact and in characteristics of the perpetrator (Davis & Chipman, 2001; Mullen et al 2009; Pinals, 2007). Options for dealing with stalking, other than victims undertaking self-protection measures (Pathé, 2002), generally comprise police action, criminal prosecution, civil legal action and/or medical intervention with the stalker. Legal sanctions alone may be effective in bringing some stalkers permanently to abandon their quest, but such interventions often fail because the fundamental problems driving the stalking behavior remain unresolved. To ignore the underlying

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psychological or psychiatric factors that led to the intrusive behavior is unwise, as it may place the same or other victims at risk of harm in the future and frequently results in unwell stalkers receiving inappropriate sentences and failing to receive treatment.

There are undoubtedly cases in which the only effective way of bringing a halt to the harassment is to incarcerate the perpetrator. However, this usually provides only temporary relief for the victim as, in most jurisdictions, this form of offense typically results in relatively brief periods of imprisonment. This leaves the victim dreading a resumption of the harassment when their tormentor is released back into the community. Such a fear is often warranted, as few stalkers receive any treatment whilst in custody which might lead them to desist from stalking. This is generally due to a lack of resources or professionals specifically trained in assessing the risks inherent in the stalking situation and delivering the necessary interventions. These problems are not unique to the custodial setting. Those who have been recognized as stalkers, but remain in the community either uncharged for the offense or on bail awaiting the court hearing, rarely undergo specialist assessment or commence treatment. The potential impact of such omissions is exemplified by cases in which victims have been killed by their stalkers as they waited for the criminal justice system to deal with their cases: well-publicized examples from the U.K. include Clare Bernal (Laville, 2007) and, from the US, Peggy Klinke and Jennifer Paulson (Logan et al., 2006, p.1–2; Murphy, 2010). In these instances, the stalkers also died, either by their own hand or shot by police. Fortunately, fatal outcomes are rare in stalking situations (Mullen et al., 2009). But this offers little comfort to those victims for whom the fear of violence is a genuine concern or who have to cope with the psychological, occupational, financial, and social sequelae of continued harassment.

Whilst the failure to provide specialist services for stalkers usually arises from financial restrictions that lower its priority in already pressured services, it is our contention that this is a false economy which ignores the full costs of persistent and recurrent stalking. Even if one takes a purely pragmatic approach, the expense for governments and the community runs into many millions of dollars in terms of police resources, repeated court proceedings, the expense of housing prisoners and/or patients, as well as a reduction in productivity in the workplace for both victims and perpetrators due to a failure to concentrate on their duties or to taking time off as sick leave or to attend to legal matters.

The purpose of this article is to explore the deficits that often exist in the management of stalkers and to offer suggestions as to how these shortfalls may be corrected. This involves consideration of current practice in the legal, medical, and psychological management of stalkers, as well as suggestions as to possible treatment strategies and service innovations.

## **LEGAL MANAGEMENT OF STALKERS**

Most stalkers initially come to attention as a consequence of the victim seeking advice and protection from the authorities. As the first point of contact, it is the police who investigate and reach an initial evaluation as to whether the behavior constitutes a criminal offense in the jurisdiction in question; and it is the police, in conjunction with the prosecuting agencies, who decide upon the appropriate form of judicial action. Stalking is, however, such a complex phenomenon, incorporating a wide range

of behaviors that vary in intensity and severity, that it has proved a difficult task for legislators to define and codify stalking behaviors into legislation that will protect society without being overly proscriptive (McEwan, Mullen, & MacKenzie, 2007; Sheridan, Blaauw, & Davies, 2003). The advances in anti-stalking legislation over the last two decades have certainly improved the protection available to victims. Nevertheless, the value of any law depends upon how it is applied. For the police, interpreting the law can be problematic in terms of determining the point at which patterns of behavior cross the legal threshold and become a criminal offence. Such difficulties have been apparent in the Australian state of Victoria, where the stalking legislation lists specific prohibited acts engaged in as a “course of conduct”, but does not define what needs to happen for such acts to constitute a course (Victorian Crimes Act, 1958, Section 21A). At times, this ambiguity has led to inconsistencies in how the law is applied, with some stalkers avoiding prosecution despite protracted harassment of the victim and others being charged for what can only be described as the most banal forms of behavior. One such extreme case is demonstrated by a man who was charged and convicted of stalking following the end of a flirtatious text message relationship. After the “victim” sent a message saying she did not want him to contact her again, he sent two text messages. The first stated “you’re joking” and when he did not receive a reply, he sent another text in which he accused her profanely of leading him on. Although the message was undeniably offensive, it could not be construed as threatening and he did not attempt to contact her again. Despite having no criminal history, he received a six-month prison sentence, suspended for two years. His behavior technically met the criteria for the offense of stalking in Victoria. However, it is not only the severity of the sentence which might be questioned, but also the fact that he was charged with stalking in the first place.

When the victim can produce evidence of repeated explicit threats or overt acts of aggression, it might be thought that the situation would be relatively straightforward. Yet, in a significant minority of cases, the police are still reluctant to become involved. Repeated intrusive behaviors of a more bizarre or surreptitious nature may be deemed innocuous gestures of affection, with the complainant eliciting dismissive, trivializing, or insensitive responses. Such instances may arise from a failure to understand the seriousness of the situation or the applicability of the law, or simply from an inefficient handling of the case (Baum, Catalano, & Rand, 2009; Pathé, 2002). As an example, in one case, a police officer attending the home of the victim of an erotomaniac neighbour kissed the victim as he departed, stating that if the stalker was watching, this might put him off. This was not only inappropriate and a form of abuse in itself, but the officer’s apparently well-intentioned act potentially increased the risk of harm to the victim. The tendency to underestimate potential harm to the victim is more pronounced when the victim is a man being pursued by a female stalker (Abrams & Robinson, 1998; Pathé & Mullen, 1997). Whilst anecdotal evidence and victim studies suggest that women are less likely to be prosecuted for stalking, research has shown that female stalkers do often engage in threatening and violent behavior (Hall, 1998; Meloy & Boyd, 2003; Purcell, Pathé & Mullen, 2001). The failure to appreciate the risks posed by different types of stalkers, whether male or female, can have serious consequences for all involved.

The police often suggest that the victim obtain a restraining or intervention order (IVO) as the first method of combating the intrusive behavior. Yet, the wisdom of seeking this as a *carte blanche* solution to all stalking cases is questionable, given the abundant examples in the literature of IVOs not only failing to protect the victim but,

in some cases, exacerbating the stalking behavior (Benitez, McNeil, & Binder, 2010; MacKenzie, Mullen & Ogloff, 2006; Montesino, 1993; Pathé, 2002). The confidence in the protection afforded by these orders may be further diminished by a reluctance of police to react to reported episodes of continuing stalking and breaches of orders (Baum, Catalano, & Rand, 2009; Pathé, MacKenzie, & Mullen, 2004). IVOs can be effective in bringing an end to harassment in suitably chosen cases (Meloy, Cowett, Parker, Hofland & Friedland, 1997), but in some situations they become “paper shields” that provide a false sense of security, especially when they are not enforced. The facts of each stalking situation and the characteristics of the individual stalker should be given careful consideration before adopting this method of management. The victim should also be made aware that it is not a substitute for adopting measures for personal protection. It is important that all breaches of the order are reported, acted upon and the matter taken before the courts.

Most courts are in a position to order mental health assessments, but the stage of proceedings at which the court can exercise this power varies between jurisdictions. Some jurisdictions allow the courts to call on the expertise of mental health professionals as a condition of bail, but in many, the earliest point for such examinations concerns the assessment of the defendant’s mental state for possible mental impairment or in relation to competence/fitness to plea (Mossman, 1998). As this is rarely applicable to stalking cases, the forensic clinician’s involvement usually concerns assisting the court with sentencing decisions or recommending interventions as a condition of parole or a correctional order. Most frequently this will occur in situations where the stalker is known to suffer from a serious psychiatric disorder or the stalker’s behavior is so bizarre that the court suspects the presence of mental illness or is simply bewildered that someone could act in the manner concerned. However, research suggests that the courts often fail to refer stalkers for assessment even when they suffer from severe mental illnesses (MacKenzie, Mullen, & Ogloff, 2006). It is unclear whether this arises from a failure of the court to recognize the severity of the stalker’s condition or a failure to recognize its importance in terms of initiating or sustaining the stalking behavior. It has been suggested that mental health provisions should be included in all anti-stalking legislation (Mullen et al., 2009) and even that all stalkers should undergo mental health evaluations (Stocker & Nielsen, 2000). The large number of stalkers coming before the civil or criminal courts would probably render the latter suggestion impracticable. The question also arises as to whether there would be sufficient numbers of appropriately trained clinicians to provide expert reports on stalkers to the courts.

In stalking cases that do reach court, the difficulties for the victim do not necessarily end there. As Pathé, MacKenzie, and Mullen (2004) have highlighted, the legal system can often be used or abused as a means of stalking by proxy. Court directives for the victim to appear as a witness or attempt conciliation through mediation can result in the legal process facilitating the stalker’s access to the victim. All too often, victims who have escaped their stalkers by changing residence have had their new location revealed to their pursuer in legal documents. Whether this occurs inadvertently or as a matter of legal procedure, for the beleaguered victim it means their efforts at self-protection have been in vain. The lengths to which the stalker will go is exemplified in a recent case from our practice in which the accused stalker entered a not guilty plea and forfeited legal representation in anticipation that he would be able both to talk to the victim through questioning her in court, and to gain full access to the legal documentation containing

her new address. In the event, the court was sensitive to the victim's plight and instructed that any evidence given would be via video link from an undisclosed location with the screen turned away from the stalker. It was also ensured that any information that might disclose the victim's whereabouts was removed from all material supplied to the stalker. With these measures in place, the stalker changed his plea and the need for the victim to give evidence was therefore avoided.

Given the problems that arise in applying anti-stalking laws, it is clearly naïve to regard legal provisions as a panacea for dealing with all stalking cases, whilst ignoring the psychiatric and psychological factors underpinning the behavior (Goode, 1995; Mullen, MacKenzie, Ogloff et al., 2006). Indeed, it is of considerable importance that police, prosecution lawyers and judges become more aware of the dangers and complexities of stalking in terms of differences in motivation and the different domains of risk and potential harm that stalking entails. Research from Europe has illustrated wide variations in attitudes and understanding of stalking in frontline police (Modena Group on Stalking, 2005; Kamphuis et al., 2005). Police forces in the U.K. are introducing a checklist for police officers of factors associated with the risk of serious violence (Sheridan & Roberts, 2011); and new guidelines for prosecutors have been issued by the Crown Prosecution Service, the body in the U.K. responsible for initiating and conducting criminal prosecutions (Crown Prosecution Service, 2010). The latter includes some detail of stalker types, with reference to the role of the Fixated Threat Assessment Centre (James et al., 2010: *vide infra*) and to the Stalking Risk Profile (MacKenzie et al., 2009), a specialized structured professional judgement tool for the assessment of all domains of risk in stalking cases.

## ASSESSMENT OF STALKERS

It is important that the criminal justice system is able to call upon a pool of psychiatric and psychological experts to advise on risks and management in stalking cases, both at the investigation stage and when perpetrators are brought before the courts. It is generally accepted that, in assessing the risks that a given perpetrator may constitute, an expert must make use of standardized risk assessment tools to aid in reaching a judgement. This ensures that the expert has covered all the bases and is making use of the most up-to-date evidence and clinical practice. In the case of stalking, the issue then arises as to which tools can be used that are suited to this particular constellation of behaviors. Given the wide variation in stalking behaviors and underlying motivations, it is not surprising that standard risk assessment tools prove inadequate when applied to stalkers, both in terms of accurately assessing the risk of violence and in terms of their failure to address other domains of stalking risk. For violence is not the only risk that stalking victims face. Other domains of risk comprise persistence, escalation, recurrence, and psycho-social damage (MacKenzie et al., 2009), and risk factors for these domains differ from those for violence and indeed differ from each other. Serious violence is fortunately uncommon in stalking, but psychological damage is ubiquitous (Blaauw et al., 2002; Kamphuis & Emmelkamp, 2001; Pathé & Mullen, 1997; Purcell et al., 2002). The questions that concern stalking victims are as follows. Is it ever going to stop? Is it going to get worse? If it stops, is it going to come back again? Answers to these questions are simply not provided by the use of generic assessment instruments which focus almost exclusively on violence. In addition, risk factors for each domain of

risk vary according to the type of stalker being assessed. To remedy this position, new tools have been developed, specifically for assessing risk in stalking situations (see McEwan et al., (2011) in this volume, for a comprehensive review). Such specialized risk assessment is a crucial first step in dealing with stalkers in that it identifies the factors that increase the risk posed by that particular individual which can then be used to guide management plans and serve as targets for intervention. The question next arises as to precisely how to intervene to manage risks, once they have been identified.

## **THERAPEUTIC INTERVENTIONS**

It would be a mistake for clinicians to assume that stalking cases are all referred by the criminal justice system. Stalking is still stalking, even when it has not led to police action or criminal prosecution. Its harmful effects and the risks it carries remain present. In countries with comprehensive social care systems, stalking cases may first be identified by public services, in particular by health services, but also by social and housing services and by other community organizations or private clinicians. Ideally, identification will lead to referral to a specialist service for assessment and treatment and, in the case of mental health services, this may involve compulsion. For many stalkers, compulsion is an essential aspect in allowing treatment to be initiated and, in a proportion, in allowing it to continue once it has been initiated. The main source of compulsion, however, still remains criminal sanction – as a bail condition, as part of a community sentence, or as a condition of parole following a prison sentence.

There are some cases of stalking in which simply educating the perpetrator as to the illegality of their behavior is sufficient to bring the harassment to an end. However, for the majority of stalkers, the behavior is underpinned by more serious and pervasive problems and treatment can be a difficult and challenging endeavor. It is the authors contention that the provision of optimal interventions requires a multidisciplinary approach which, at a minimum, encompasses both psychiatric and psychological components. It is beyond the scope of this article to provide a comprehensive manual of treatment options (see Mullen et al., 2009; Pinals, 2007). Rather, the authors will provide here a summary of the extant treatment research, an account of the most pressing therapeutic concerns, and suggestions as to how many of the existing deficits in treatment and in overall service provision could be overcome.

## **CURRENT RESEARCH INTO TREATMENT**

It should be stated at the outset that there is a dearth of outcome research on treatment interventions in stalking. Treatment trials require consideration not only of attitudinal and behavioral change, but also of recidivism and conviction or reconviction over a period of follow-up that is measured in years rather than months. The offence of stalking is relatively new in many jurisdictions, and such trials have yet to be undertaken.

The only empirical research to date that has investigated the efficacy of treatment was conducted by Rosenfeld and colleagues (2007). Their study evaluated a six-month treatment program adapted from dialectical behavior therapy (DBT), a technique developed by Linehan (1993) for working with people with borderline personality

disorder. The program focused on the DBT component which addresses the development of behavioral control. It retained the basic format of DBT with a weekly one-hour skills group followed by a 45-minute individual session, and between-session telephone coaching. Of the 29 male stalkers referred, none of the 14 who completed the treatment engaged in officially recorded recidivistic stalking behavior in the 12-month, post-completion, follow-up period. This was in marked contrast to the 27% of treatment drop-outs who reoffended. Whilst one cannot dismiss the possibility that those who dropped out of treatment were those most likely to reoffend, the results do suggest that DBT may be an approach worth exploring in some stalkers.

There are, however, serious difficulties with placing such diverse offenders as stalkers into group programs. Group therapy is contraindicated in some stalkers, for instance the overtly aggressive, those with serious mental illness or cognitive impairment, or individuals with psychopathic or severe narcissistic traits. Group therapy would also be unsuitable for those individuals who feel resentful and justified in their pursuit of their victim and for whom placement in a group with like-minded individuals would provide an opportunity for reinforcement of their perception of injustice. Such a situation would be disruptive to group dynamics and limit overall efficacy. Group work is sometimes seen as a desirable treatment mode for reasons of reduced cost. However, attendance failures are disruptive to all participants, and may result in important elements of the treatment being omitted. As regards the DBT model, the wisdom of giving between-session telephone access to some stalkers is also open to question.

It has been suggested that psychodynamic psychotherapy might have a place in the treatment of stalking (J. Reid Meloy, personal communication, January 2010). The efficacy of short- and long-term psychodynamic psychotherapy as treatments for psychological and emotional problems has recently been supported through meta-analyses (Leichsenring & Rabung, 2008; Shedler, 2010), although their methodology, study samples and conclusions have been criticized (Beck & Bhar, 2009; Gerber, Kocsis, Milrod et al., 2011). Such therapies, whilst they have a considerable number of advocates, particularly in the U.S.A., are not available everywhere as part of contemporary mainstream psychiatric practice. At least in our jurisdictions, there are few correctional settings where such therapies are available, and criminal courts are generally unsympathetic to psychodynamic psychotherapy as a court-mandated treatment (Grounds, 1996). The use of the psychodynamic approach as a treatment in offender populations has been criticized on the basis that many offenders lack the necessary verbal intelligence and motivation, and that treatment fails to focus on developing pro-social contingencies (Andrews & Bonta, 2007). Diagnostically, a substantial proportion of non-ex-intimate stalkers suffer from psychotic disorders such as schizophrenia, in the treatment of which psychodynamic psychotherapy is said to have “no current place” (Cunningham Owens & Johnstone, 2009, p. 583). Psychodynamic concepts are certainly of use in formulating an understanding of individual stalking cases, particularly in relation to attachment issues (MacKenzie, Mullen, Ogloff, McEwan, & James, 2008). But evidence as regards a role for psychodynamic psychotherapy in the treatment of stalkers is currently lacking.

Although there is little empirical data regarding the treatment of stalkers, research and clinical experience show us that the factors underlying stalking behaviors encompass a wide range of psychiatric and psychological issues. These vary between and within the different stalker motivational types. In consequence, we advocate a multidisciplinary team approach to the clinical management of stalkers which employs

a range of treatment methods to address the individual's specific needs as determined through assessment (Warren et al. 2005).

## PSYCHIATRIC MANAGEMENT

The literature provides strong evidence that mental disorders are common among stalkers and, as with any group of offenders, the types of disorder vary widely (James & Farnham, 2003; Kienlen, Birmingham, Solberg, O'Regan, & Meloy, 1997; Meloy, 1996; Meloy & Gothard, 1995; Roberts, 2002). Stalking behaviors may be concurrent with or driven by serious mental illness. Delusional disorders, schizophrenia, bipolar affective disorder, and major depression have all been found to occur frequently in forensic stalker populations (Kienlen et al., 1997; Meloy & Gothard, 1995; Mullen, Pathé, Purcell, & Stuart, 1999; Roberts, 2002; Schwartz-Watts & Morgan, 1998; Schwartz-Watts, Morgan, & Barnes, 1997; Zona et al., 1993). Such conditions, when present, offer an obvious focus for psychiatric intervention. In these cases, the stalking usually ceases when the disorder has been controlled and the delusional beliefs regarding the victim abate. The manifestations of some forms of illness may change over time, (e.g., a manic episode reverting to a period of depression), or spontaneously resolve (e.g., a substance-induced psychotic illness settling with abstinence from the causative agent). However, in most instances delusional symptoms are likely to persist unless treated with antipsychotic medications, and pharmacotherapy must be the initial treatment in such stalkers.

The content of delusions that underlie the harassment of the victim is most commonly persecutory or erotomanic. Delusions of jealousy – the belief that one's spouse or lover is unfaithful – are also relevant in stalking but only after the dissolution of the original relationship (Mullen, 1990). When these beliefs occur as a part of a schizophrenic illness, treatment may be relatively straightforward, although some cases will inevitably be more resistant to treatment than others. Matters are more problematic when delusions occur in an otherwise organized individual (e.g., in delusional disorder), who tends to be high-functioning in all areas beyond the delusional belief. The serious nature of their condition is often missed by the courts and, in some cases, by clinicians (MacKenzie, Mullen, & Ogloff, 2006). Yet, if left untreated, the delusions (and therefore the stalking) will persist. Even where a positive result is obtained with the use of antipsychotics, low-grade residual beliefs may often remain, albeit in a muted form (Myers & Ruiz, 2004). Given that psychotic stalkers rarely have insight into their illness, they are unlikely to comply with treatment, and therefore to desist from their intrusive behavior unless compelled to do so by the courts or through the use of civil mental health legislation. In such cases, involuntary commitment to a psychiatric hospital may be necessary in the first instance. This usually requires the use of a secure facility. In addition, detention is almost always necessary for a longer period than is usual in an era of managed care. Particular problems may arise in this respect with cases of delusional disorder or organized schizophrenic presentations, as prolonged treatment in hospital in the absence of behavioral disturbance is unusual outside of forensic psychiatric services. Consequently, in jurisdictions where forensic hospitals also treat civilly detained patients, this may prove the best option when in-patient treatment is not mandated by a court. The potentially serious consequences of the stalker relapsing through non-compliance determine that depot antipsychotic preparations are the formulation of



choice in treating stalkers with psychotic illnesses and that community treatment orders, where available, should follow on from involuntary commitment. The therapeutic negativism with which cases of delusional disorder are sometimes met by clinicians is to be avoided. Early recourse to the use of clozapine in cases of treatment-resistant psychotic disorder is advisable.

In practice, there are often difficulties in obtaining comprehensive treatment for stalkers who suffer from serious mental illness. The pressures of resource limitations in many jurisdictions determine that the primary concern of mental health services becomes the risk of self-harm or the risk of violence to others. It is, of course, essential that both of these issues are considered with every stalker. Serious violence is the ultimate fear in many stalking situations, and too often the eventual outcome. Stalkers appear to be at greater risk of committing suicide than other types of offenders or general psychiatric populations (McEwan, Mullen, & MacKenzie, 2010), and the possibility that suicidal ideation may lead to desperate acts such as killing the victim and/or family members before killing themselves cannot be discounted. However, the taking of such a restricted perspective results in the other domains of risk inherent in the stalking situation being given low priority or completely ignored as assessment and treatment concerns or responsibilities. This does little to alleviate the anxieties of victims who are left to cope with persistent or recidivistic stalkers and the concomitant fear and the detrimental personal, social, economic and psychological impacts associated with the continuing harassment.

Despite these potential difficulties in the treatment of psychotic disorders, the psychotic stalker may be viewed as a straightforward case in which to intervene, in that services whose purpose is to treat major mental disorder are widely developed. This is in stark contrast to services available to deal with the majority of stalking cases, in which a major mental disorder is conspicuously absent and the harassing behavior is underpinned by psychological factors or dysfunctional personality traits. Many stalkers have a diagnosable personality disorder, with the most frequent types being the borderline, the histrionic and the narcissistic (Harmon et al., 1995; Meloy & Gothard, 1995; Mullen et al., 1999; Zona et al., 1993). Antisocial personality disorder has also been identified in stalkers, albeit at a lower prevalence than is found in general populations of incarcerated males (Meloy, 1996; Reavis, Allen, & Meloy, 2008). Finding appropriate avenues of treatment for stalkers with personality disorders is challenging as they often require long-term intervention and appropriate treatment programs are in short supply in the majority of mental health services. A similar problem arises for those perpetrators whose pursuit of the victim is driven by a paraphilic disorder (Mullen et al., 2009). Whilst many jurisdictions provide treatment for sex offenders, these programs are typically confined to the correctional setting. In addition, they are usually in a generic group format that does not cater for the needs of those who require tailored individual therapy or who would benefit from treatment with anti-libidinal medication. Furthermore, there is little on offer for those who experience deviant fantasies in the absence of a serious mental illness and have not been convicted of an offense.

As the situation stands in most countries, psychiatric services are poorly equipped to address the psychological and behavioral factors that underpin stalking, either through lack of resources or through a lack of expertise or therapeutic confidence. In consequence, there is often an understandable fear of taking on the responsibility for treating stalkers beyond pharmacological treatment of psychotic drive. Yet the

risks to victims and stalkers do not disappear because the treatment role is abdicated. These gaps in service provision raise important questions as to how and by whom psychological interventions for stalkers should be conducted.

## PSYCHOLOGICAL INTERVENTIONS

Psychological interventions form the mainstay of the treatment of non-psychotic stalkers, and provide a second stage in the treatment of psychotic stalkers, once their symptoms have been sufficiently stabilized for the therapeutic focus to be moved to addressing other aspects of the problem behavior.

It is clear from the literature that there is no one “type” of stalker, but rather a variety of motivations and stalker types (Mullen et al., 2009; Pinals, 2007). However, it is our experience that stalkers share some common attitudinal states and skills deficits that are fundamental to the development and perpetuation of stalking behavior. It is these factors that undermine their ability to adopt more adaptive and appropriate methods of interpersonal interaction, and it is these factors that need to become the targets for treatment.

The common dominator in all stalking episodes, no matter what the motivation, is the stalker’s strong sense of entitlement concerning the victim – the belief that they have a right to the fulfilment of their own desires and that they deserve the victim’s time and attention in furthering their goals. Some stalkers have the egocentricity and grandiose sense of self characteristic of the narcissist and psychopath (Storey, Hart, Meloy & Reavis, 2009). But, in the majority of stalkers, their sense of entitlement is a more circumscribed trait that only becomes problematic in a particular context. In the stalking situation, this sense of entitlement generally manifests itself in rationalizations and justifications of their behavior. These are based on the belief that they have a “right” to be heard, to receive an explanation, to have their grievance addressed, to express their love or to be treated with respect. The stalking evolves when their rights take precedence over all other concerns related to the victim.

In addition to their sense of entitlement, stalkers typically show a marked indifference to their targets’ desires and fears. In some, this is a conscious disregard for the victim’s feelings, even pleasure in the victim’s fear and distress. For others, there is either a lack of comprehension or reckless disregard of the harmful consequences of their behavior. In some, misconstruing or misrepresenting the victim’s actions may be based in delusional beliefs, in which overt rejection is interpreted as evidence of romantic interest. Yet, in other cases, there appears to be a wilful lack of concern for the victim’s feelings in the absence of obvious psychopathology.

The final common element in stalking cases is the presence of skills deficits that lead the stalker to adopt maladaptive means of pursuing their goals and desires. These deficits often concern verbal skills, social skills, conflict resolution, problem-solving and reasoning skills, and problems with emotional regulation. In addition to becoming offense-specific treatment targets, these may also serve as particular responsivity issues – factors that may impede treatment and serve as potential barriers to response to interventions.

### Responsivity Factors

In exploring how to increase the efficacy of offender treatment, Andrews and Bonta (2007) suggested a model based on the individual’s risks, needs and responsivity

(RNR). They propose that the best outcomes regarding recidivism are achieved when treatment is delivered to high-risk offenders, addresses specific criminogenic dynamic risk factors and uses cognitive behavioral interventions that take the individual's personal characteristics into account. These characteristics, which include personal strengths, learning style, personality and motivation to change, are referred to as responsivity factors. The core of the RNR model is that an individual's various strengths and deficits have a strong bearing on the overall benefits they derive from therapy. These individual traits are crucial to the efficacy of treatment, as they have the potential to impact negatively on the course of treatment, or to provide areas of strength on which to draw to help effect change (Ogloff & Davis, 2005).

Responsivity factors frequently encountered with stalkers include anti-social attitudes, values, and beliefs; low or inflated self-esteem; cognitive rigidity; and problematic anger. The stalker's intellectual functioning also warrants attention, as it is fundamental to the design and delivery of any treatment intervention. Research suggests that, while most stalkers have average non-verbal intellectual abilities, they often have relatively poor verbal skills (MacKenzie, James, McEwan, Ogloff, & Mullen, 2010). This not only raises the possibility of receptive or expressive communication skill deficits, but also highlights potential issues with the manner of treatment delivery. By understanding the cognitive strengths and weaknesses of the stalker, the clinician will be in a better position to determine the optimal approach to treatment. Through identifying responsivity factors, the clinician will be able to maximize the gains that the individual can achieve from treatment by exploring potential barriers to treatment that will need to be addressed and tailor the style of therapy to best suit the client.

### **Readiness to Change**

The efficacy of any psychological intervention is reliant on the individual having the desire to change, as well as willingness and ability to engage. These issues have been addressed in the Multifactor Offender Readiness Model (MORM) proposed by Ward, Day, Howells, & Birgden (2004). The MORM is based on the premise that therapeutic change is enhanced when the offender is ready for treatment. The offender's 'readiness' is determined by individual, program and context factors. (For a full description of the model see Day, Casey, Ward, Howells & Vess, 2010.) The approach we take in treating stalkers adopts the fundamental principles proposed in the MORM in that we tailor the content and delivery of treatment according to the individual's internal and external needs, fragility and issues of responsivity as well as their cognitive style and ability. The context of the treatment (mandated as opposed to voluntary) is also taken into account with a focus on the development of therapeutic rapport that is conducive to change and the stalker's involvement in the establishment of specific treatment goals. Without these essential elements, it is unlikely that the stalker will be willing or able to make the changes necessary to end their pursuit and reduce the risk of recidivism.

A useful framework to assist in considering the stalker's motivation to change their behavior and in shaping the delivery of treatment is the transtheoretical model of intentional behavior change (DiClemente, 2003, 2005; DiClemente & Prochaska, 1998). This model, which is widely used in changing health-related behaviors (Casey, Day & Howells, 2005), conceives the process of behavioral change as comprising five stages with identifiable goals that must be attained in order to instigate, consolidate, and

maintain the desired change: pre-contemplation, contemplation, preparation, action, and maintenance. The transtheoretical model has been shown to be useful when incorporated into the treatment of a range of problem behaviors, including sex offending (e.g., Tierney & McCabe, 2005), addictions (DiClemente, 2003) and domestic violence (Begun, Shelley, Strodthoff & Short, 2001). The model was originally developed for addictive or habitual behaviors that usually have a high observable frequency that enables close monitoring of progress. Given that many offense behaviors such as violence have a relatively low base rate, the suitability of using the model for such offending has been questioned, particularly in the custodial setting where abeyance is enforced and participation in treatment influences parole decisions (Casey, Day & Howells, 2005). The issue of determining the efficacy of treatment in the custodial setting is an important point in terms of stalking treatment overall, and reinforces the centrality of a community focus for treatment, including supervision and ongoing treatment post-release for offenders who have been imprisoned and patients who have been hospitalized.

Whilst adopting elements from various psychological therapies in the treatment of stalkers, it is useful to utilize the labels of the stages of change from the transtheoretical model to describe the stalkers' cognitive readiness to change. The following demonstrates how we apply this concept. In the first stage, pre-contemplation, the stalker has no intention of changing their behavior, as they do not regard it as problematic. Increasing the stalker's awareness of why their action is a problem can sometimes be achieved through discussing the effect on the victim. Victim impact statements may assist in imparting this message. Education regarding what constitutes stalking can be reinforced by working through the relevant legislation with the stalker. Having the stalker articulate what they hoped to achieve with regard to the victim when they first commenced stalking and then compare this to the actual outcome, in relation to both their own situation and to the impact on the victim, can be used as a means of showing stalkers the futility of their endeavor.

The goal of the contemplation stage is to bring stalkers to accept that their behavior is a problem and to come to the decision that they want to change. Reinforcement of the personal advantages of ceasing the harassment can be undertaken through cost-benefit analyses, both for continuing and for stopping the behavior. Prompting may be required for the stalker fully to appreciate the full costs of persistence, including the consequences from legal, financial, emotional, and time perspectives. Stalkers should be helped to accept the failure of their pursuit through cognitive reframing, in a manner which fosters change in the beliefs that maintain the behavior, whilst enabling them to preserve their dignity. For stalkers who claim success in their goals (particularly when the intent is creating fear and distress), identifying and emphasizing the personal costs of continuing in the same manner may be the only means of establishing meaningful dialogue.

The next stage, preparation, involves the development of plans to change the behavior. This requires the clinician to describe the issues to be addressed, derived from the dynamic risk factors identified in assessment. The clinician must endeavor to frame these in a positive manner, so that the stalker can see the benefits of each change. Involving the stalker in the selection of therapeutic targets gives them a sense of ownership which increases the likelihood of their committing to treatment. The new behaviors are then put into practice in the action stage. It can often prove difficult for stalkers to abandon entrenched behaviors and implement change. Encouragement

through the positive reinforcement of pro-social behavior and the identification of alternative activities to replace the maladaptive behavior can assist the stalker through this difficult phase. Lapses should be analyzed in an objective and constructive manner which enables the recognition of trigger factors and facilitates the development of strategies for avoiding potential high-risk situations.

Success in the maintenance stage requires the identification of any current factors which might impede therapeutic progress and increase the risk of recurrence. The risk of relapse may be reduced through the joint development of contingency plans to deal with potentially perilous situations, including the environmental and the social, as well as with specific emotional states. Emphasis is placed on the benefits of maintaining commitment to abstinence, with gentle reiteration of the detrimental consequences of relapse.

The treatment targets are those factors identified as problems for the individual and usually require a mixture of therapeutic approaches. After treatment targets are identified, they need to be prioritized so that the most pressing issues are addressed. The methods we advocate are those that have been shown to have empirical validity including interpersonal, cognitive behavioral, and behavioral therapy techniques, as well as social cognition theory (the processing of information through the development of schemas, attributions or stereotypes) and the relapse prevention paradigm. This is combined with education regarding the methods to overcome their particular deficits, such as conflict resolution, emotional regulation, and social and communication skills.

## SERVICE INNOVATIONS

Effective assessment and development of management plans for stalkers requires the availability of individuals who are trained in determining risk in stalking situations. The importance of mental illness, psychological problems, and vulnerable personality factors in initiating and driving stalking behaviors, necessitates the involvement of mental health professionals, if comprehensive and meaningful assessment is to be achieved. The difficulty with this is that, in the absence of serious mental illness, stalkers rarely fall within the remit of mental health services. The question then arises as to possible frameworks in which specialist assessment and treatment can be achieved. Examples of two very different service models designed to overcome such deficits in service provision are described below: the Fixated Threat Assessment Centre (FTAC) in the U.K. and the Problem Behavior Program in Australia.

FTAC was established in 2006 to assess and manage the risk to politicians and to members of the British royal family from individuals who stalk, harass, threaten, or inappropriately pursue them. The service won an award for policing excellence from the U.K. Association of Chief Police Officers in 2009. Whilst its focus is on the prominent as a victim group, the principles on which it operates have been recognized as having potential wider applicability in responses to stalking (James et al., 2010). FTAC's essential characteristic is that, whilst being a police unit, it is jointly staffed by police officers and by psychiatric nurses, psychiatrists and psychologists from the National Health Service, whose posts are funded by the Department of Health. These health personnel are trained in the use of the Stalking Risk Profile (MacKenzie et al., 2009). The joint approach brings a psychological and psychiatric perspective to the handling of stalking cases, as well as facilitating psychiatric interventions and treatment

in cases where this is appropriate. By collating information from both policing and medical sources, FTAC is able to provide comprehensive reports on cases and specialist assessment of different types of risk, as well as guidance on management and treatment. Whilst this may entail police action, it usually involves referral to psychiatric services in the area in which the individual resides. It is their responsibility to provide treatment, which in cases of those with psychotic illness is usually in the context of involuntary commitment. However, FTAC is also able to advise police and psychiatric services in the management of difficult cases by sending personnel around the country to meet with members of different agencies handling cases. Advice can be provided to police, to family doctors, social services, families and to any other relevant community agency. This is probably of most value to local clinicians in terms of people who do not fit into the group that psychiatric services would normally consider for compulsory detention, such as some cases with delusional disorder or paranoid personalities. FTAC staff are able to advise on an area which is unfamiliar to many clinicians, and also help develop inter-agency management plans for dealing with more problematic cases. FTAC acts both as a catalyst for intervention by extant services, and also as a specialist resource which can advise other agencies on how to evaluate and manage people who stalk the prominent. The model is now being advocated as suitable for adoption in the general population in the management of problematic stalking cases. Whilst FTAC does not detain or treat, one of its main functions is to assist psychiatric services around the country so to do.

In contrast to FTAC, the Problem Behavior Program (PBP) at the Victorian Institute of Forensic Mental Health (Forensicare) in Melbourne, Australia, was developed not only to provide expert assessments for those that engage in problem behaviors such as stalking, but also to offer an avenue of treatment for those where existing services failed to treat or lacked the requisite skills. The mandate for Forensicare, as with most forensic and general mental health services, was to assess and treat individuals with serious mental illness. In addition to managing a secure forensic hospital, Forensicare was given the responsibility throughout Victoria of overseeing the reintegration of forensic clients into the community, as well as providing community services for offenders with serious mental illnesses. Although the focus of Forensicare's community operations was in working with those whose offenses were committed in the context of psychiatric disorder, it also ran a community assessment and treatment service for sexual offenders and research clinics for stalkers and threateners, few of whom were mentally ill. From the flood of referrals requesting assessment and treatment of such cases, it soon became apparent that there was a substantial gap in service provision for high-risk offender groups whose needs were not being met by either the public or private health sectors. In 2003, the PBP was formally established through the amalgamation of the existing clinics to cater for those who engaged in problem behaviors, with or without the presence of mental illness (Warren, MacKenzie, & Mullen, 2005).

The criteria for referral to the PBP is that the individual is considered as, or suspected of being, at significant risk of engaging in behaviors that lead to serious physical or psychological harm. These behaviors include violence, sexual offences against adults or children, fire-setting, threatening, and stalking-related acts. Most referrals come from the courts, correctional services, area mental health services, and private clinicians primarily within Victoria, but also from other states. In addition, there have been increasing numbers of individuals who self-refer or attend voluntarily in order to address their problems in the absence of criminal charges. As the profile of the program

has grown, referrals have increased markedly and the PBP has now become a major component of Forensicare's community operations.

The PBP is staffed by consultant psychiatrists and clinical and forensic psychologists who work in conjunction to provide comprehensive assessments and treatment options. The bulk of the work entails conducting assessments and offering treatment recommendations for the referrer to implement in their own service, with outside support, if necessary. However, with high-risk cases whose treatment needs are failing to be met by other services, treatment is provided by the PBP. A collaborative team approach is used, in which individual clinicians have the advantage of working in an environment in which they receive the clinical support of colleagues and share the responsibility of potential risk. An important plank in this arrangement is the holding of regular review meetings, which serve as an important learning environment in which the experience and expertise of senior clinicians is shared with their colleagues and with those training to become the next generation of clinicians.

Since its inception, the PBP has conducted thousands of assessments. By providing a concentration of expertise, it has become a fertile resource and an example of good practice in dealing with problem behaviors. In addition, a substantial body of research has been produced, particularly in the area of stalking. Through this, the PBP has gained recognition nationally and internationally as a center of excellence for its work with a wide range of offender groups. The clinicians in the program provide education to external organizations in both the public and private sectors, including the courts. They present their research at international conferences and in specialist journals. The PBP has also become a much sought-after clinical placement for those seeking to expand their knowledge of assessing and treating problem behaviors.

The PBP is undertaking a joint research project with Monash University which involves a trial of a standardized intervention for treating stalking behaviors. This research, supported by a large grant from the Australian Research Council's Discovery Project scheme, includes a randomized controlled trial of a 6-month psychological stalking treatment program conducted at the PBP. The treatment protocol incorporates the principles from the risk, needs, and responsivity literature (Andrews & Bonta, 2006) and the other treatment methods discussed earlier. The experimental intervention takes a cognitive behavioral and skills enhancement approach, combined with elements of the transtheoretical model and informed by the tenets of social cognition theory. The risks and needs identified through a comprehensive assessment form the foundation of treatment targets that are addressed through a selection of prescribed therapeutic modules. The treatment is then delivered in weekly individual sessions.

Stalkers receiving the experimental treatment will be compared with a 'treatment as usual' group, and with stalkers who do not attend for recommended treatment. The efficacy of the intervention will be investigated using a minimum 12-month follow-up of police and public mental health databases to establish reoffending, with permission also obtained from participants for a prospective ten-year follow-up.

## **PROTECTING THOSE WORKING WITH STALKERS**

Clinicians in psychiatric services may come into contact with those who have engaged in stalking behaviors, or with stalking victims, through community health or prison

services or the judicial process. Although many mental health workers are apprehensive about treating stalkers out of concern that they will become a target, transference of abnormal feelings and abnormal attention to the therapist by stalker patients is an infrequent occurrence (Mullen et al., 2009). Of far greater risk are patients who have not been identified as stalkers. In working with individuals who have psychiatric or psychological problems, there is often a sense of being divorced from the stalking phenomenon, with a perception that the professional role offers protection when care is delivered objectively. The fact is frequently overlooked that, in working with such a disturbed and dysfunctional population, the professional is vulnerable to becoming a target themselves. There is a growing body of literature that highlights the risk posed to clinicians of becoming victims of stalking, particularly those who work with mentally ill patients (Galeazzi, Elkins, & Curci, 2005; McIvor & Petch, 2006; Mullen, Pathé & Purcell, 2009; Pathé, Mullen, & Purcell, 2002; Purcell, Powell, & Mullen, 2005; Sandberg, McNiel, & Binder, 2002). Whether the harassment occurs because the clinician has attracted the amorous or the malicious attention of a patient, the consequences, both personally and professionally, can be disruptive and potentially devastating.

The extent of the damage that can be wreaked is illustrated by the case of Jan Falkowski, a consultant psychiatrist in Britain, who was stalked for three years by Maria Marchese, the partner of a patient. At the outset, Marchese embarked on an anonymous campaign to sabotage the wedding of Dr Falkowski and his then fiancée Deborah. The couple were subjected to a barrage of terrifying telephone calls, e-mails and text messages threatening to kill Deborah and the wedding guests. It was made clear they were being watched and their houseboat was broken into and flooded with gas. Despite Marchese's eventual apprehension, she went uncharged and recommenced her harassment. Under the strain of the ordeal, the couple separated and Dr Falkowski commenced a new relationship. Marchese then accused him of drugging and raping her, supporting her allegations with underwear that proved to contain traces of his DNA. Dr Falkowski was charged and subsequently suspended from his job. After 18 months, the rape case collapsed when it was proven that the underwear contained the DNA of three people. It transpired that Marchese had obtained Dr Falkowski's DNA from a condom she had found in his dustbin. The stalking case was reopened and Marchese eventually received a nine-year prison sentence. Dr Falkowski's harrowing ordeal has recently become the topic of the docudrama, *U Be Dead* (Hughes & Payne, 2009).

Clinicians are not the only ones susceptible to victimization by stalkers. In our experience, the police and even the judiciary can attract a stalker's unwanted attention, be it romantic or resentful. In one of our cases, a stalker attempted to burn down the house of a judge who had upheld a ruling against her. In another, a police officer was bombarded by telephone calls from a woman who had become besotted with him after he arrested her for stalking. Understanding the intrinsic risks should be a crucial component in the training provided to those likely to encounter stalkers in a professional capacity (Mullen, Pathé, & Purcell, 2009). Care should be exercised about allowing information into the public domain that might help a stalker contact or locate individuals outside the workplace. Public listings of home addresses in telephone directories or voters' registers should be avoided, and participation in social networking, such as Facebook or Twitter, is to be discouraged. For lone practitioners who are not afforded the protection of working within a large organization, careful consideration



should be given to the wisdom of working with this population in isolation, and attention paid to ensuring office security.

Within health and social care organizations, there should be a policy of zero tolerance of threats and a protocol for immediate response measures when clients engage in any behavior that is not acceptable. Traditionally, there has been a culture of tolerance in the helping professions to inappropriate behavior by patients or clients. However, such tolerance not only places the clinician, their family and co-workers at greater risk of escalating intrusions, it seldom proves to be in the client's best interests in the longer term (Pathé, Mullen, & Purcell, 2002). It is essential that patients are informed at the outset that, if they behave in unacceptable manner, they risk disengagement from the service and potential legal consequences. If the individual does not desist from unreasonable behavior, employees across the service, including receptionists, need to be alerted to concerns and the need for documentation and reporting. The service has to be prepared to follow through on warnings given to an individual, as failing to do so risks greater boundary violations.

All organizations and businesses have an ethical and, in many jurisdictions, a legal obligation to protect their employees. Employers, especially in larger organizations and services, need to be aware that stalking can both originate in or intrude upon the workplace. It can involve the targeting of individuals in their personal capacity or as representatives of an organization that has attracted a stalker's ire. The onus is on organizations to ensure workplace safety through the development and enforcement of policies and procedures that address all forms of harassment.

The importance of education about early warning signs of aberrant attention, about the types of unacceptable behaviors concerned, and about the need to report them, cannot be over-emphasized. Employees are often reluctant to report what may appear to be minor events, either through embarrassment or fear of appearing an alarmist, overly sensitive or somehow at fault. Managers need to be sensitive to these issues and encourage reporting in order to remain abreast of all events. What may appear to be an isolated incident to one witness might reveal a pattern of behavior when combined with what others have experienced or seen. Employees at all levels must be brought to appreciate the importance of protecting not only their own personal information, but also that of their colleagues and clients.

## CONCLUSIONS

Our contention in this article is that the adoption of specialist programs, such as the PBP, should be considered in other jurisdictions as a means to overcome the deficiencies that currently exist in most areas in the services provided in stalking cases. This would benefit all agencies involved, including stalkers, their victims, the police, and the courts. The provision of specialist assessment and management services, whatever the model, requires resources. However, there is a need to set this, in a cost-benefit analysis, against other financial considerations: policing costs of responding to stalking incidents; the costs of taking individuals to court; the cost of imprisonment; the cost in lost production for those victims who, because of the stalking itself or its psychological sequelae, are obliged to take time off work; and the costs of treating psychological and, on occasion physical damage to the victims and also to the stalkers themselves. To be added to this are elements which are of a social value which is not

readily financially quantifiable; diminishing the psycho-social impact of stalking; and preserving public confidence in the police and the criminal justice system.

All those involved with either stalkers or their victims should be trained in assessment of the risks involved, including those of mismanagement (Kamphuis, Galeazzi, et al., 2005; Mullen, Pathé, & Purcell, 2009). This is particularly pertinent for mental health professionals who have an essential role, not only in the assessment and treatment of stalkers and their victims, but also in conducting research and ensuring the dissemination of information that can instruct clinicians, law enforcement agencies, the judiciary, policy-makers, and members of the general public alike.

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