Chapter 18
Stalking, Threatening, and Harassing Behavior by Patients--The Risk Management Response

It has been said that no good deed ever goes unpunished. Perhaps it is the clinician's burden to experience this firsthand, and it is in this context that Sandberg et al. (2002) have made, once again, an important contribution to research on stalking. Their study is the first not only to delineate the traits and behaviors of civil psychiatric patients who threaten, harass, and stalk clinicians, but also to detail the response strategies of clinicians to such disturbing events.

Although their inquiry looked at a broad range of threatening and harassing behavior, not just stalking, it appears that mental health clinicians, especially female nurses, are at greater risk to be victimized by such behavior than the general population. Lifetime risk of stalking victimization, when rigorously defined, affects 1 in 12 adult women in the United States and 1 in 50 adult American men (Tjaden & Thoennes, 1997). The findings of Sandberg et al (2002) should surprise no one, especially clinicians who have had extensive inpatient experience.

In a similar vein, the clinical and demographic characteristics of the patients who stalked, threatened, and harassed staff in this civil study are almost identical with findings in forensic settings (Meloy & Gothard, 1995; Harmon et al., 1998). Males are four times more likely to engage in this behavior than females, and they are typically a decade older than most males who act criminally or approach a criminal threshold for threatening behavior. They are clinically heterogeneous, and personality disorder is a likely comorbid diagnosis for almost half of them. Although Sandberg *et al.* did not attempt to map the Axis II geography of this sample further, we and other researchers (Meloy et al., 2000; Mullen et al., 1999) have found a likelihood of Cluster B personality disorders in forensic samples, but a lower frequency of antisocial personality disorder when compared with other criminals. This latter finding appears to be a product of an attachment disorder that is preoccupied rather than dismissive (Meloy, 1998).

The patients in the study by Sandberg et al (2002) were usually motivated by "angry, retaliatory behavior in response to some form of perceived mistreatment" (p 224). This finding, often the motivation for stalking in workplace settings (Mullen et al., 2000), raises the further question of sensitivity among these patients: Why do they retaliate when most patients, subjected to similar treatments, do not? I suggest that a common thread among such patients is a pathological narcissism that increases the risk of humiliation in response to the more confrontational aspects of treatment, especially inpatient care. This ventral underbelly of shame sensitivity can stoke a fury that makes no distinction between the professional and private life of the clinician. The study underscores the importance of a comprehensive diagnostic workup that does not neglect both personality and substance abuse disorders, even in the face of a florid Axis I psychosis.

These civil patients also do what most stalkers in forensic samples do: They threaten, harass through letters and the telephone, and follow. Fortunately, severe cases and physical attacks were rare in this study group. This is probably a product of two phenomena: the nature of the relationship to the victim and the risk-management response of the clinician. Interpersonal violence among forensic samples of stalkers ranges from 25 percent to 40 percent, and when stalkers of prior sexual intimates are studied

alone, violence frequencies substantially exceed 50 percent (Palarea et al., 1999; Meloy et al., 2001). Although the sample in the study by Sandberg et al (2002) is small, the physical attack (6%) and property destruction (5%) frequencies were remarkably low and remind me of the first study a decade ago of violence among stalkers in which a six percent frequency of violent incidents was reported (Zona et al., 1993).

The risk-management data provide some insight into this success. Every one of the responses by the clinicians reportedly "made things better," although the clinicians were "very or extremely upset." Perusal of their 15 risk-management responses suggests that the guiding wisdom is for the victim to be proactive, but not to confront the patient directly. It has appeared to me for several years that the worst response for a stalking victim is to initiate direct contact with the threatening person. Regardless of what is said or the affect that is exchanged, the act itself becomes an intermittent positive reinforcement and causes a significant increase in pursuit behavior Meloy, 2002). In a recent analysis of data on women who stalk, we found that initiating contact with the stalker by the victim increased subsequent pursuit in 68% of the cases (Meloy & Boyd, 2003).

Consultation, containment, and confrontation by third parties (e.g., police, security, coworkers, attending physician, clinical director) were effective risk-management tools in the study by Sandberg et al (2002). I also suggest that a preventive policy measure is worth consideration. Whenever a written, e-mail, or telephonic communication is sent by an ex-patient to an inpatient staff member, even if it is not threatening, a two-part response should follow. The clinician to whom the communication was sent should do nothing and the director or administrator of the program should send a polite and clear form letter to the patient, stating that it is the policy of the program that such communications are not reciprocated by the individual clinician. This is likely to dilute any feelings of rejection and introduces a third-party authority into the interpersonal space that may be imbued with wishful fantasy.

Notwithstanding the infrequent use of legal means by the clinicians in the study by Sandberg et al (2002), I am reminded once again that mentally ill individuals sometimes threaten and attack those who are trying to help them. Whether the behavior is motivated by anger, envy, delusion, or myriad other experiences, the time may come when the patient becomes a criminal, and prosecution is warranted (Rachlin, 1994; Meloy, 1991). Although the mentally ill appear to be neither more nor less violent than anyone else after discharge, unless they use illicit drugs (Steadman et al., 1998), comparative studies of large samples of individuals do not diminish the threat that one patient may pose to a mental health professional, especially if the patient intrudes into the clinician's personal life.

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