Stalked by a 'patient'

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For 20 months, Ms. I has been calling and sending threatening letters to a psychiatric resident whom she falsely believes is her physician. How can he respond safely and ethically?

CASE Delusions and threats

For over 20 months, Ms. I, age 48, sends a psychiatric resident letters and postcards that total approximately 3,000 pages and come from dozens of return addresses. Ms. I expresses romantic feelings toward the resident and believes that he was her physician and prescribed medications, including "mood stabilizers." The resident never treated Ms. I; to his knowledge, he has never interacted with her.

Ms. I describes the resident's refusal to continue treating her as "abandonment" and states that she is contemplating self-harm because of this rejection. In her letters, Ms. I admits that she was a long-term patient in a state psychiatric hospital in her home state and suffers from persistent auditory hallucinations. She also wants a romantic relationship with the resident and repeatedly threatens the resident's female acquaintances and former romantic partners whose relationships she had surmised from news articles available on the Internet. Ms. I also threatens to strangle the resident. The resident sends her multiple written requests that she cease contact, but they are not acknowledged.

What should the resident do?

a) inform law enforcement of the potential danger Ms. I poses
b) safeguard his own physical and psychological welfare
c) notify Ms. I's family and care providers about her conduct
d) arrange psychiatric care for Ms. I
e) reassure Ms. I that she will not be abandoned

The authors' observations

Stalking—repeated, unwanted attention or communication that would cause a reasonable person fear—is a serious threat for many psychiatric clinicians.[1] Prevalence rates among mental health care providers range from 3% to 21%.[2,3] Most stalkers have engaged in previous stalking behavior.[3]

Being stalked is highly distressing,[4] and mental health professionals often do not reveal such experiences to colleagues.[5] Irrational feelings of guilt or embarrassment, such as being thought to have poorly managed interactions with the stalker, often motivate a self-imposed silence (***Table 1***).[6] This isolation may foster anxiety, interfere with receiving problem-solving advice, and increase physical vulnerability. In the case involving Ms. I, the psychiatric resident's primary responsibility is safeguarding his own physical and psychological welfare.

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Clinicians who work in a hospital or other institutional setting who are being stalked should inform their supervisors and the facility's security personnel. Security personnel may be able to gather data about the stalker, decrease the stalker's ability to communicate with the victim, and reduce unwanted physical access to the victim by distributing a photo of the stalker or installing a camera or receptionist-controlled door lock in patient entryways. Security personnel also may collaborate with local law enforcement. Having a third party respond to a stalker's aggressive behavior—rather than the victim responding directly—avoids rewarding the stalker, which may generate further unwanted contact.[7] Any intervention by the victim may increase the risk of violence, creating an "intervention dilemma." Resnick[8] argues that before deciding how best to address the stalker's behavior, a stalking victim must "first separate the risk of continued stalking from the risk that the stalker will commit a violent act."

Mental health professionals in private practice who are being stalked should consider retaining an attorney. An attorney often can maintain privacy of communications regarding the stalker via the attorney-client and attorney-work product privileges, which may help during legal proceedings.

RESPONSE Involving police

Over 2 months, Ms. I phones the resident's home 105 times (the resident screens the calls). During 1 call, she states that she is hidden in a closet in her home and will hurt herself unless the resident "resumes" her psychiatric care. The resident contacts police in his city and Ms. I's community, but authorities are reluctant to act when he acknowledges that he is not Ms. I's psychiatrist and does not know her. Police officers in Ms. I's hometown tell the resident no one answered the door when they visited her home. They state that they would enter the residence forcibly only if Ms. I's physician or a family member asked them to do so, and because the resident admits that he is not her psychiatrist, they cannot take further action. Ms. I leaves the resident a phone message several hours later to inform him she is safe.

Table 1

Factors that can impede psychiatrists from reporting stalking

Fear of being perceived as a failure
Embarrassment
High professional tolerance for antisocial and threatening behavior
Misplaced sense of duty

Source: Reference 6

What legal duties does the psychiatric resident have to Ms. I?

a) provide emergency care
b) direct Ms. I toward appropriate psychiatric services
c) prevent her from engaging in self-harm
d) none to Ms. I, but a legal obligation to inform others if they may be in danger
e) none beyond any general duty citizens owe each other

The authors' observations

Stalking-induced countertransference responses may lead a psychiatrist to unwittingly place himself in harm's way. For example, intense rage at a stalker's request for treatment may generate guilt that motivates the psychiatrist to agree to treat the stalker. Feelings of helplessness may produce a frantic desire to do something even when such activity is ill-advised. Psychiatrists may develop a tolerance for antisocial or threatening behavior—which is common in mental health settings—and could accept unnecessary risks.

A psychiatrist who is being stalked may be able to assist a mentally ill stalker in a way that does not create a duty to treat and does not expose the psychiatrist to harm, such as contacting a mobile crisis intervention team, a mental health professional who recently treated the stalker, a family member of the stalker, or law enforcement personnel.

continued

Clinical Point

Stalking-induced countertransference responses may lead a psychiatrist to unwittingly place himself in harm's way

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Table 2

Classification of stalkers

Category	Common features
Rejected	Most have a personality disorder; often seeking reconciliation and revenge; most frequent victims are ex-romantic partners, but also target estranged relatives, former friends
Intimacy seeking	Erotomania; "morbid infatuation"
Incompetent	Lacking social skills; often have stalked others
Resentful	Pursuing a vendetta; generally feeling aggrieved
Predatory	Often comorbid with paraphilias; may have past convictions for sex offenses

Source: Adapted from reference 1

Clinical Point

A delusional wish for treatment or a false belief of already being in treatment does not create a duty to care for a person

A psychiatrist who is thrust from the role of helper to victim and must protect his or her own well-being instead of attending to a patient's welfare is prone to suffer substantial countertransference distress.

The situation with Ms. I was particularly challenging because the resident did not know her complete history and therefore had little information to gauge how likely she was to act on her aggressive threats. Factors that predict future violence include:

- a history of violence
- significant prior criminality
- young age at first arrest
- concomitant substance abuse
- male sex.[9]

Unfortunately, other than sex, this data regarding Ms. I could not be readily obtained.

A psychiatrist's duty

Although sympathetic to his stalker's distress, the resident did not want to treat this woman, nor was he ethically or legally obligated to do so. An individual's wish to be treated by a particular psychiatrist does not create a duty for the psychiatrist to satisfy this wish.[10] State-based "Good Samaritan" laws encourage physicians to assist those in acute need by shielding them from liability, as long as they reasonably act within the scope of their expertise.[11] However, they do not require a physician to care for an individual in acute need. A delusional wish for treatment or a false belief of already being in treatment does not create a duty to care for a person.

OUTCOME Seeking help

Ms. I's phone calls and letters continue. The resident discusses the situation with his associate residency director, who refers him to the hospital's legal and investigative staffs. Based on advice from the hospital's private investigator, the resident sends Ms. I a formal "cease and desist" letter that threatens her with legal action and possible jail time. The staff at the front desk of the clinic where the resident works and the hospital's security department are instructed to watch for a visitor with Ms. I's name and description, although the hospital's investigator is unable to obtain a photograph of her. Shortly after the resident sends the letter, Ms. I ceases communication.

Counterthreats are least effective with stalkers who suffer from:

a) comorbid medical conditions
b) psychosis
c) depression
d) histrionic personality disorder
e) substance abuse

The authors' observations

This case is unusual because most stalking victims know their stalkers. Identifying a stalker's motivation can be helpful in

formulating a risk assessment. One classification system recognizes 5 categories of stalkers: rejected, intimacy seeking, incompetent, resentful, and predatory (***Table 2***).[1] Rejected stalkers appear to pose the greatest risk of violence and homicide.[8] However, all stalkers may pose a risk of violence and therefore all stalking behavior should be treated seriously.

Responding to a stalker

The approach should be tailored to the stalker's characteristics.[12] Silence—ie, lack of acknowledgement of a stalker's intrusions—is one tactic.[13] Consistent and persistent lack of engagement may bore the stalker, but also may provoke frustration or narcissistic or paranoia-fueled rage, and increased efforts to interact with the mental health professional. Other responses include:

- obtaining a protection or restraining order
- promoting the stalker's participation in adversarial civil litigation, such as a lawsuit
- issuing verbal counterthreats.

Restraining orders are controversial and assessments of their effectiveness vary.[14] How well a restraining order works may depend on the stalker's:

- ability to appreciate reality, and how likely he or she is to experience anxiety when confronted with adverse consequences of his or her actions
- how consistently, rapidly, and harshly the criminal justice system responds to violations of restraining orders.

Restraining orders also may provide the victim a false sense of security.[15] One of her letters revealed that Ms. I violated a criminal plea arrangement years earlier, which suggests she was capable of violating a restraining order.

Litigation. A stalker may initiate civil litigation against the victim to feel that he or she has an impact on the victim, which may reduce the stalker's risk of violence if he or she is emotionally engaged in the litigation. Based on the authors' experience, as long as the stalker is talking, he or she generally is less likely to act out violently and terminate a satisfying process. Adversarial civil litigation could give a stalker the opportunity to be "close" to the victim and a means of expressing aggressive wishes. The benefit of litigation lasts only as long as the case persists and the stalker believes he or she may prevail. In one of her letters, Ms. I bragged that she had represented herself as a pro se litigant in a complex civil matter, suggesting that she might be constructively channeled into litigation.

Promoting litigation carries significant risk.[16] Being a defendant in pro se litigation may be emotionally and financially stressful. This approach may be desirable if the psychiatrist's institution is willing to offer substantial support. For example, an institution may provide legal assistance—including helping to defray the cost of litigation—and litigation-related scheduling flexibility. An attorney may serve as a boundary between the victim and the pro se litigant's sometimes ceaseless, time-devouring, anxiety-inducing legal maneuvers.

Counterthreats. Warning a stalker that he or she will face severe civil and criminal consequences if his or her behavior continues can make clear that his or her conduct is unacceptable.[17] Such warnings may be delivered verbally or in writing by a legal representative, law enforcement personnel, a private security agent, or the victim.

Issuing a counterthreat can be risky. Stalkers with antisocial or narcissistic personality features may perceive a counterthreat as narcissistically diminishing, and to save face will escalate their stalking in retaliation. Avoid counterthreats if you believe the stalker might be psychotic because destabilizing such an individual—such as by precipitating a short psychotic epi-

Clinical Point

Consistent lack of engagement may bore the stalker, but also may provoke frustration or narcissistic or paranoia-fueled rage

Related Resources

- National Center for Victims of Crime. Stalking resource center. www.victimsofcrime.org/our-programs/stalking-resource-center.
- Mullen PE, Pathé M, Purcell R. Stalkers and their victims. New York, NY: Cambridge University Press; 2009.

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Clinical Point

Counterthreats can be risky with stalkers with antisocial or narcissistic personality features or psychotic individuals

sode—may increase unpredictability and diminish their responsive to interventions.

Ms. I's contact with the resident lasted approximately 20 months, slightly less than the average 26 months reported in a survey of mental health professionals.[3] Because stalkers are unpredictable, the psychiatric resident remains cautious.

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Bottom Line

The primary obligation of a clinician who is stalked is to safeguard his or her own physical and psychological welfare. Neither a stalker's need for psychiatric treatment nor his or her psychotic belief that he or she had been treated by a psychiatrist creates a duty to provide treatment. Interventions include silence, establishing a restraining order, and issuing a counterthreat, but the approach must be tailored to the stalker's characteristics.