

Stalking of mental health professionals: an underrecognised problem

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Summary Doctors and mental healthcare professionals are at greater risk of being stalked than the general population, particularly by their patients. Despite causing significant psychological distress, stalking remains underrecognised and poorly managed. Healthcare organisations should ensure appropriate policies are in place to aid awareness and minimise risk, including the provision of formal educational programmes.

Declaration of interest None.

Stalking has been defined as a constellation of behaviours involving repeated and persistent attempts to impose on another person unwanted contact and/or communication (Mullen *et al*, 1999). Contact can occur by loitering, following, surveillance and making approaches, and communication can be made by either conventional or electronic means (Pathé & Mullen, 1997). Stalking can escalate and lead to intimidation, threats or violence. Anyone can be the victim of stalking, including previous or present partners, casual acquaintances and friends, professional contacts, workplace colleagues, strangers, or those in the media spotlight. Stalking appears common: in a large US telephone survey, 8% of women and 2% of men said they had been stalked at some point in their life (Tjaden & Thoennes, 1997). One widely used classification of stalkers is based on motivation: the rejected, the intimacy seeker, the resentful, the incompetent suitor and the predatory (Mullen *et al*, 1999). The importance of this classification is that it helps predict risk and behaviour patterns, and informs management approaches.

RISK TO HEALTHCARE STAFF

Doctors and healthcare professionals are at greater risk than the general population of being stalked, particularly by their patients (Pathé *et al*, 2002; Purcell *et al*, 2005b). Pathé & Mullen (1997) found that healthcare professionals, particularly medical staff, were overrepresented in a sample of self-referred victims to a stalking clinic. However, incidence and prevalence rates in this population remain largely unknown (Lion & Herschler, 1998), owing to international differences in definition and legal status. Threats and violence that occur in clinical practice need to be distinguished from the repetitive and persistent behaviour typical of stalking.

All clinical staff are at risk. Romans *et al* (1996) reported that 5% of counselling centre staff had been stalked by clients, but 64% had experienced some sort of harassing behaviour. Psychiatrists and those working in related sub-specialties, such as forensic psychiatry, may be at higher risk. In one study, clinicians attending a US state psychiatric conference were surveyed using a fairly strict definition of harassment. Nearly a third had been subjected to stalking and a further 41% reported other forms of distressing intrusions, including damage to property (Lion & Herschler, 1998). Psychologists also appear to be at higher risk, according to results from two large random surveys. Gentile *et al* (2002) found that 10% of a sample of American psychologists had experienced serious stalking events during their careers, and in an Australian sample Purcell *et al* (2005b) found that nearly 20% had experienced stalking, nearly half of which had occurred in the previous year.

Several studies have surveyed mental health staff working within defined settings. Sandberg *et al* (2002) surveyed all clinical staff employed in an American in-patient psychiatric unit. Over half the respondents had experienced some type of

stalking, threatening or harassing behaviour during their career, including threats, telephone calls and unwanted approaches. Following and violence were rare. Perpetrators usually targeted staff members who had previously treated them. Staff found the behaviour upsetting and disruptive, particularly if it continued for more than 3 weeks. Staff commonly confronted the patients about their behaviour, but did not find this strategy particularly helpful.

Patients who stalked staff were significantly more likely than a comparison group to have a diagnosis of personality disorder and/or paranoid disorder. In addition they were more likely to have never been married, to misuse drugs and alcohol, and to have a history of assaultive, fear-inducing and self-harming behaviour, and multiple hospitalisations (Sandberg *et al*, 1998).

In a recent Italian survey (Galeazzi *et al*, 2005), mental health professionals working in public and private practice within a defined geographical area were screened for harassment by patients. With a high response rate, a third of staff were found to have been harassed in one of nine defined ways, and 11% were found to have been stalked, using a strict operational definition. Clinicians were occasionally threatened, but physical attacks were rare. Most of the victims were nurses, but psychiatrists and psychologists experienced extended periods of stalking. As with the American study, the stalkers – most of whom had a diagnosis of psychosis or personality disorder – tended to target staff who were directly involved in their care.

Both genders can stalk staff: Sandberg *et al* (1998) and Purcell *et al* (2005b) suggested that patients who stalked staff were more likely to be male, but Purcell *et al* (2001) found that it was female stalkers who were more likely to target professional contacts. Regarding victims of stalking, there is growing evidence to show that male mental health workers are at greater risk (Gentile *et al*, 2002; Galeazzi *et al*, 2005).

IMPACT OF STALKING

Stalking can have a significant impact upon psychological, occupational and social functioning for the person stalked (Pathé & Mullen, 1997; Purcell *et al*, 2005a). For healthcare professionals this can lead to increasing stress, fear, helplessness and disenchantment (Sandberg *et al*, 2002).

More overt psychiatric illness may develop, which can have an impact on the functioning of the healthcare service. Behavioural and security changes may be employed to reduce risk (Galeazzi *et al*, 2005).

WHY ARE HEALTHCARE STAFF AT INCREASED RISK?

As a rule of thumb stalkers do not tend to have normal psychological or personality profiles, and by definition those who target mental health professionals are more likely to suffer from significant psychological difficulties. Stalkers tend to have difficulties in forming and maintaining interpersonal relationships and those who target clinicians may harbour unrealistic or misplaced expectations of intimacy arising from the normal therapeutic relationship. This is particularly so for intimacy seekers or incompetent suitors. For example, in the Italian survey the majority of mental health professionals reported the patient's desire for more intimacy as the perceived motivation (Galeazzi *et al*, 2005). In addition, through the ending of a therapeutic relationship, rejected stalking may emerge.

Patients may be overtly psychotic, their delusional system driving stalking behaviour (Sandberg *et al*, 1998, 2002). This may be complicated by substance misuse. Interestingly, pure erotomania – the delusional belief of being loved by a target of higher social or professional status – is comparatively rare (Kienlen *et al*, 1997).

Not surprisingly, patients with non-psychotic stalking, particularly those suffering from personality disorder, display different motivations for their behaviour. In a sample of stalkers targeting individuals in the general population, the non-delusional cohort was influenced by factors such as anger and hostility, projection of blame, obsessional behaviour, dependency, minimisation and denial, and jealousy (Kienlen *et al*, 1997). These factors may be at work within the clinical setting, particularly with patients who have long-standing interpersonal attachment difficulties. It has been suggested that the common thread in such patients is a narcissistic drive that defends against humiliation in response to the more confrontational aspects of treatment, especially in-patient or coercive care (Meloy, 1999).

Projection of blame can be a potent motivation for stalking, particularly within the 'resentful stalker' typology. Patients may develop a grudge for some perceived

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wrongdoing or dereliction of duty on the part of the doctor or healthcare worker. This can extend beyond the individual, with complaints being made to hospital authorities and professional regulators.

Victim factors may play a part in the persistence of stalking behaviour. Doctors and other healthcare professionals may develop a degree of tolerance to antisocial or threatening behaviour, because of its prevalence in their everyday practice. As a result they may minimise persistent harassment, in the hope that it will resolve spontaneously or be managed within the therapeutic relationship. This perception may be reinforced by feelings of guilt or inadequacy concerning clinical practice or expertise, or concern at what colleagues might think. Unfortunately, supervisors or healthcare providers may reinforce such perceptions, either covertly or blatantly. Because of the patient's mental illness, there may be a reluctance to involve the police or criminal justice system in managing the problem.

INCREASING AWARENESS

Stalking of healthcare professionals is a common occupational hazard, yet it remains underresearched and underreported, and can lead to significant distress and psychiatric morbidity. Clinicians receive little training in the concept of stalking or its management, even though their profession renders them more likely to become victims. Despite increasing emphasis on risk assessment in relation to suicide, violence and homicide, explicit awareness of stalking remains limited. Healthcare organisations should consider adopting formal educational programmes covering recognition of stalking behaviour and risk management strategies, particularly for staff in the early stages of their career. Appropriate policies should be in place for dealing with stalking, and staff should be advised and supported throughout the process.

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