Treatment of Stalking-Offenders

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Abstract: Treatment of Stalking-Offenders

Mental health professionals are now becoming more and more confronted with stalking cases - the therapeutic intervention is the best possible approach for the prevention of further escalation of the situation. The intervention dilemma describes that each intervention can contribute to further escalation; an assessment, gathering collateral information and planning the intervention strategy help to avoid negative consequences.

Indirect intervention helps targeted victims to cope with the threat; whereas direct interventions are addressed towards the offender. Such intervention are best carried out under the umbrella of a legal framework. Health care service providers have to cooperate with law enforcement authorities in such cases. The author discusses practical considerations in the assessment and management of stalking offenders.

"*Using the cops to crack crime is like taking aspirin for a brain tumor*". Philip Marlowe, quoted in Gilligan, 2001.

This paper provides an exploration of possible treatment approaches when dealing with stalking offenders. It is based on treatment experiences and training seminars given by the author. Health care professionals have to enlarge their knowledge when dealing with this subject in at least three areas. (1) Treatment modalities are directed more by threat management concepts than by traditional therapeutic interventions. The best documented treatment approach for stalking offenders is DBT (Dialectic Behavior Therapy). (2) In threat management mental health issues play a complete different role than in traditional clinical settings – treatment of stalking offenders is not primarily based on mental health issues, but on behavioral aspects. And (3) mental health care professionals can no longer claim confidentiality when dealing with stalking offenders – they have the duty to balance legal requirements, and to inform targeted persons (this must be done according with the legal framework).

Mental health care professionals are now becoming more and more confronted with stalking cases

When the first stalking cases were reported two decades ago, the problem was associated with topranking officials and celebrities. However, in the meantime it turned out that stalking is part of domestic and workplace violence, and that it affects many more people then ever thought before. Depending on the definition of stalking, between 15% and 20% of the entire population may become a victim of stalking during their lifetime. The average duration of stalking is approximately two years with a wide ranging duration from a couple of days until decades. In most cases victims never know for sure, when the stalking really ends – thus creating ongoing fear and panic attacks and often contribute to a significant impairment of life-quality. It is not the unknown stranger who commits stalking – empirical facts show that in 70% of all stalking cases the offender is known to the victim; and in approximately half of all stalking cases the stalking behavior emerges from a former intimate relationship. To make it even more complicated: stalking is not a unique behavior, rather it is a chain of behavioral aspects targeted towards the victim, in most cases in order to threaten the person. Sometimes the behavior is just annoying. When it goes on and on over a long period of time, it may have a considerable impact on someone's life. In a quarter to a third of all cases the stalking behavior includes physical violence, ranging from slapping to life-threatening attacks.

Between half and three quarters of all victims need professional help due to an impairment of their mental health conditions. The symptoms ranging from sleep disturbances and nightmares, to panic-reactions, constant fear leading to avoidance behavior and undermining working capacity; somatic problems such as headaches, chronic fatique syndrome, gastrointestinal disturbances, and chronic pain, just to name the most prominent problems. Therefore health care professionals will see stalking-victims and their relatives, and there is a urgent need to train health care providers in this area. But mental health care professionals will also be confronted with the question: What to do with the offenders? Delegating this problem to the criminal justice system or to forensic medicine works only in severe cases, but does not cover the wide range of problematic behavior issues related to stalking. Many may believe that as long as these problems do not arrive on their doorstep there is nothing to be done – a rather naïve view of the world. Health care professionals may easily become the victim of stalkers themselves, as various studies clearly indicate. 15-20% of health care providers are themselves confronted by stalkers; and approximately 50% become victims of workplace violence. Again the question is: What to do with these offenders?

Law enforcement helps!

Certainly this answer is true. One of the primary goals of law enforcement is to protect the citizen. But when is comes to threatening behavior legal approaches are soon exhausted. A simple knock at a stalker's door helps in approximately two third of all cases and contributes to bringing the stalking to an end – at least for that time. However, it may continue with another victim; in a third to nearly half of all cases stalking is a repeated behavior, targeting new victims. A restraining order and of course victim treatment including providing security advice can be of help. As you may be aware, most stalkers deny entirely that they have a problem – the problem is the victim. If she would not behave this way, there would not be a need for such a reaction. It's naïve to expect that stalkers will be motivated to undergo treatment and to change their behavior. Without a legal framework any therapeutic approach will fail.

Another important aspect is the question: What should therapy provide in these cases? Assuming that their exists no solution is not very helpful, as Mullen et al. (2000) note: "*defining them as unchangeable makes them unchangeable".* When you consider therapy as a kind of a last resort, then this approach will fail. Therapy helps best when implemented early after the threatening behavior erupts. Stalking, as any other

threatening and violent behavior, is not a disease – we estimate that only a third of all stalkers can be diagnosed at the time of their threatening behavior as having a serious mental health issue. And even in cases, when they are diagnosed with mental health problems, it is often not clear whether the threatening behavior is caused by mental impairment, or whether it simply co-occurs.

The treatment approach in stalking cases is based on a change in behavior rather than treating a mental health problem. This includes problem solving techniques, anger management, and social skills training. Many stalkers suffer from attachment problems and related unresolved grievances – in such cases therapy may by an option in changing someone's life. The dialectic approach of DBT is helpful in overcoming the tunnel vision that nothing can be changed. The same approach that the American President Obama uses in his rallying cry can be adopted in therapy in order to provide a vision: Yes, we can! Therapy may really change someone's behavior. The therapeutic alliance is the base for this approach, where therapy goes with the client, and not against him.

Case vignette

The case example illustrates various aspects of stalking, please read it in order to get a brief overview of the problems we face when talking about treatment as an option in the management of stalkers.

> *On June 8, 2007, Roland Nef was appointed chief of the joint Swiss Armed Forces. Nobody seemed to realize at the time, what he had done – despite the security checks which are required for such a job. On July 13, 2008, investigative journalists disclosed in the media what they knew about the highest official for Swiss security – leading to Nef's resignation on July 25, 2008, 10:23am. Between Nef and his intimate partner things had gone bad – and she finally left the relationship in February 2005. About a month later she received her first anonymous post-card. During the following year, Nef stalked her using e-mails and text messages; he also placed sex ads under her name. On September 27, 2006 she reported him to the law enforcement authorities. On January 26, 2007 Nef's private home was investigated and he was put in cuffs. All the time, Nef claimed this to be a private matter.*

This case clearly illustrates therapeutic limits – when the aim of stalker treatment is on changing behavior and preventing further escalation, the intervention has to start early in its development; this is in most cases of the type when difficulties in relationship arise. The case also indicates how private matters can affect the workplace. According to what we know from the media, Nef obviously does not suffer from a diagnosable mental health disorder; the intervention would therefore only focus on his behavior and aims to help him improve his social skills relating to intimate partnerships. The case also illustrates a common phenomenon – high achievers often suffer from personality deficits, if not to say from psychopathic traits, as Babiak and Hare note in their book (2006). Again, in the view of the offenders, they don't have a problem, it is others.

Therapeutic intervention

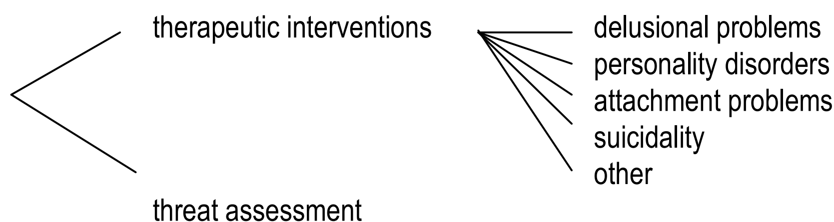
The therapeutic approaches to violent cases are always based on two different avenues: one is the therapeutic intervention per se, the other is the ongoing threat assessment based on the clinical interview. These two aspects have to be dealt with simultaneously during the intervention process. In case of a threat against third parties the responsibility always lies with the treating therapist to warn potential targets, according to the Tarasoff Doctrine. Although this "*Tarasoff duty to warn*" philosophy was coined by an

American Court it is now applicable worldwide, as a recent European Court on Human Rights' decision clearly indicates (Gavaghan 2007). Professionals can no longer claim confidentiality, rather they have to balance rights, especially concerning security aspects of third parties. However, reporting must be based on legal avenues designed for such situations, otherwise it would consist of a breach in confidentiality. The threat assessment is not a single event, rather it must be updated periodically, or when new information is available, which leads to a revision of the puzzle. The threat assessment should be done by an interdisciplinary team (Resnick 2007). The information management is crucial and professionals involved in the situation should always consider collateral information. The single most accurate predictor is always the targeted victim!

An example of the importance of the information management can be seen clearly in a recent case of a psychiatric assessment (Neue Zurcher Zeitung 2007):

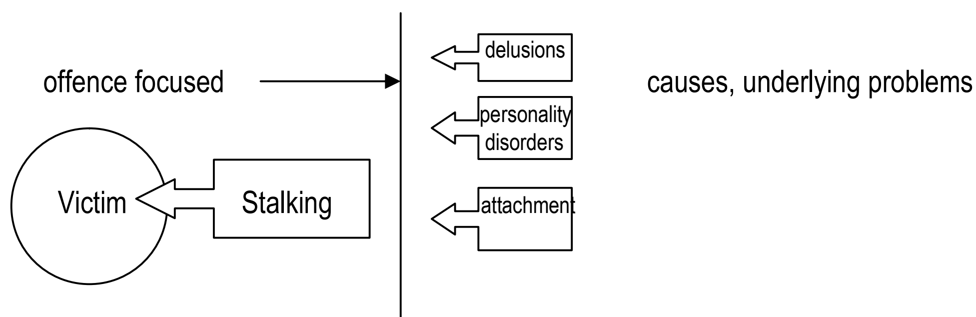
> *A 53 year old man was released from a psychiatric ward after a local court decision. A psychiatrist evaluated the man and provided a risk assessment without considering collateral information. The man was involuntary admitted to a psychiatric ward due to his threatening behavior on September 1st, 2007. A judge released the man based on the professional's assessment, on September 7th. Neither the judge nor the assessing psychiatrist consulted the physician who had admitted the man to the psychiatric ward, nor did they consult with the psychiatrists of the ward who knew the man quite well from previous hospitalisations, nor did the judge consult the police registry. On September 16, 2007 the man killed a cab-driver by stabbing him with a knife.*

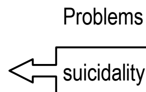
When stalkers are referred for treatment, there are at least four salient psychiatric problems which are a challenge for therapeutic interventions, as illustrated in the following list:



I have described this approach in Ireland et al.'s book (see Tschan 2009). In stalker treatment, focusing on the offence pattern means, that we consider the stalking behavior per se as the main aspect which brings someone into treatment, and not so much the underlying problems. In other words: «*Traditionally, most areas of psychiatry have focused on disorders of mental function, with behavior regarded as a mere epiphenomenon*» (Mullen 2007).

The offence focused treatment is illustrated in the following diagram:





The offence-focused treatment is based on a semistructured cognitive-behavioral intervention approach consistent of 24 moduls (see: http://www.bsgp.ch/userdocs/APA2006%20Stalking.pdf). A contract right at the beginning of the treatment clarifies rights and duties. The specific treatment goals can be divided into offence and personality focused aspects.

offence focused:

- offence reconstruction
- cognitive distorsions
- underlying causes
- impulse control (internal-external)
- offence related personality aspects
- victim empathy
- improving impulse control
- openness
- intimacy and emotionality
- responsibility
- work – life-balance
- crisis-management

personality focussed:

- anger management
- power and powerlessness
- own victimisation
- social skills
- fear-reduction
- substance abuse
- eating problems
- identity and self esteem
- nature and ecology
- ethical concerns
- personal perspectives
- spirituality

In most cases the first goal is to stop the stalking behavior, and then to address any underlying problems. The treatment operates using a hierarchical concept, where problems related to threat escalation are dealt as a priority. In cases of escalation it is of primary importance, to be prepared for violent outbursts, which require a close co-operation with law enforcement authorities. Over the last two decades more than a dozen different stalking typologies has been published: with Zona et al. providing the first of these typologies in 1993. For therapeutic approaches these static concepts are not very helpful, nevertheless professionals treating stalkers would do well to have a knowledge about the various concepts.

After the offence focused approach we consider specific therapeutic challenges related to the individual stalking case. This approach is comparable with DBT and uses various elements of it; however the offence related intervention technique is derived from treatment experiences of violent and sexual offenders. The model of Prochaska and DiClemente (1992) on changing behavior and the motivational interview technique (Miller et al. 1991) are implemented in this treatment approach.

DBT in stalking cases

A recent publication by Rosenfeld et al. (2007) discusses the application of DBT (Dialectic Behavior Therapy) for the treatment of stalking offenders. In a sample of 29 individuals DBT was applied in a six-months treatment program, 14 completed the treatment. *Treated offenders were significantly less likely to re-offend with another stalking offense (0 of 14) compared to treatment drop-outs (26.7%) or to published*

recidivism data (47%) (Rosenfeld et al. 2007). These study suggest that DBT is applicable for stalking offenders and that this kind of therapeutic approach may significantly reduce stalking behavior. In the application this approach does not primarily focus on a particular diagnostic category, but on problematic behavior as the primary target of change. DBT has demonstrated efficacy with forensic patients (McCann et al. 2007), as well as with difficult to manage clients, as described by Linehan (1993). In the discussion of the outcome-results Rosenfeld et al. outline an interesting point: ".. *the lack of association between psychopathy ratings and treatment outcome might indicate that this intervention is equally effective with both psychopathic as well as non-psychopathic offenders*". This clearly indicates that traditional mental health approaches in stalking cases, when they focus on diagnostic categories instead on behavior issues, can be misleading.

Conclusion

The aim of this contribution is to provide an overview on the treatment approach for stalking offenders, which focuses on problematic behavior rather than on diagnostic categories. Punishment does not decrease recidivism in stalking cases. The treatment is offence-focused and aims to change problematic behavior. The concept of Prochaska and DiClemente on changing behavior is applied for structuring the therapeutic process; and motivational interview techniques are used to improve therapeutic cooperation. The intervention technique can be divided in offence focused aspects and personality aspects. The semistructured therapeutic approach allows therapists to focus on particular individual problems (e.g. attachment problems, social skill deficits, suicidality, etc.). The intervention dilemma describes, that each intervention may contribute to a dramatic escalation of the situation. The standard of care requires health care professionals to warn third parties, when they learn about an explicit threat against an identifiable target, a duty which challenges confidentiality issues.

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