Stalking: Intervention and Treatment.
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Chair: Gail E. Robinson
- Gail E. Robinson, University of Toronto. Stalking: overview and treatment of victims.
- Karen M. Abrams, University of Toronto. Stalking interventions and treatment
- Totti Karpala, Helsinki: Threat Management by multi-agency joint cooperation.
- Werner Tschan, University of Zurich. Treatment of Stalkers: Challenging the intervention dilemma.

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Abstract

Treatment of Stalkers : Challenging the intervention dilemma.

The “Intervention Dilemma” is a term used to describe the risk due to any form of intervention in stalking cases. This means, that any intervention might contribute to a dramatic escalation in the situation and lead to a violent outburst. On the other hand if you do not intervene in protecting those affected there is a considerable risk of continued suffering. Therefore, in some stalking cases it is better not to intervene directly but, rather, focus on counselling the victim about how to manage the situation. This approach is addressed as a “defensive” strategy, in which, although the stalker usually does not realize the intervention, it could contribute to a de-escalation of the entire situation.

Any direct intervention is addressed as an “offensive” strategy, whether it is therapeutic, legal (e.g. restraining order, etc.), or by the police. In handling stalking cases interdisciplinary cooperation is essential for both the risk assessment and the management of individual cases. Therapeutic interventions are based on an offence-focused approach, which first of all aims to stop the stalking behaviour. Secondly underlying problems and psychiatric illnesses are addressed, such as delusional disorders, personality disorders, attachment problems, etc. Special attention is required when suicidal intentions are present, because this often leads to very dangerous stalking situations due to the risk of extended suicide. The study of risk factors in severe stalking cases indicates that the traditional forensic risk assessment is inadequate in predicting further escalation. The author discusses the concept of an offence focused treatment approach for stalkers

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Introduction

After severe physical attacks by her male partner she was about to separate from him, when he began to stalk and to threaten her. She took all her belongings and fled to her parents. With the intention to protect their daughter the parents reported the case to the police, who then approached the stalker and warned him. However, instead of stopping his behavior the stalker then began threatening the parents making

phone calls, saying that he will kill their daughter. He also posted ads in the neighborhood saying that their daughter was a prostitute and alike.

In the case the police intervention led to an escalation of the entire problem. What the involved professionals learned from this case was that the police require special knowledge about stalking cases; and the need for a special team among police forces to deal with threatening behavior. This would help the police to appropriately intervene and to protect affected persons.

Pragmatic interventions

The case management in stalking situations is crucial. Interventions made in a given case are always based on a comprehensive risk assessment. Often the determinants for escalation of threatening behavior are based much more on «dramatic moments» (Meloy 1996) than on personality traits and pathologies. A pragmatic approach in stalking cases requires knowledge on underlying offender strategies. As far as we know today, only about a third of stalkers have a diagnosable mental disorder; therefore the focus on the offence pattern is essential.

When the aim of the intervention is to bring the stalking behavior to an end, it should not be forgotten, that treatment interventions for victims can also help to stop the stalker – often by clear and unambiguous answers. The therapeutic interventions focus on solving ambivalent feelings (especially when the ex-partner is the stalker) and provides the victim with basic security measures (e.g. expressing a clear message that the stalker should not contact the person anymore; to not reply to any correspondence whatsoever; to buy a second cell phone and reserving the first for the stalker, etc.). This strategy is more defensive, where the stalker is unaware about the intervention; and it may contribute in avoiding any further escalation. On the other hand, any offensive strategy which is addressed to the stalker directly may increase the risk for violent outbursts. Often there is a need for close cooperation with law enforcement authorities due to the inherent risk of escalation. This situation is addressed as the intervention dilemma (White et al. 1998).

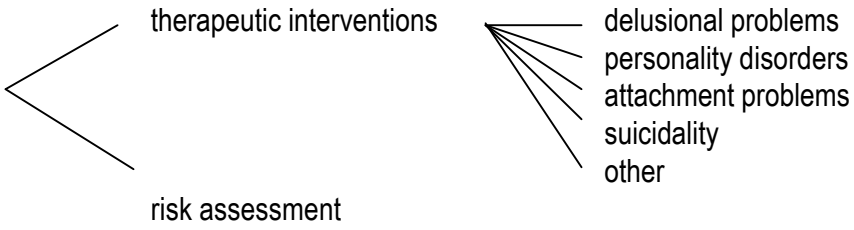
The therapeutic approach in stalking cases is always based on two different avenues: one is the therapeutic intervention per se, the other is the ongoing risk assessment. These two aspects have to be dealt with simultaneously during the intervention process. In case of an increased risk to third parties 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. The risk 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 risk 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.

An example of the importance of the information management can be seen clearly in a recent case of a psychiatrist assessing a woman’s ability to carry a handgun (Neue Zurcher Zeitung No. 79, April 5/6, 2008):

The lady's handgun had been confiscated by the police after she tried to shoot an ex-lover. She had been in treatment for the last three years with a female psychiatrist who refused to provide her with a medical report to retrieve her gun from the police (Unbedenklichkeitserklaerung) due to her instability. The woman then found another highly regarded psychiatrist age 66 who after seeing her for a one hour session concluded that she was stable and in good enough mental condition to retrieve her gun. At no time did the psychiatrist seek collateral information, such as background check, contacting the treating psychiatrist, or counseling with law enforcement officials.

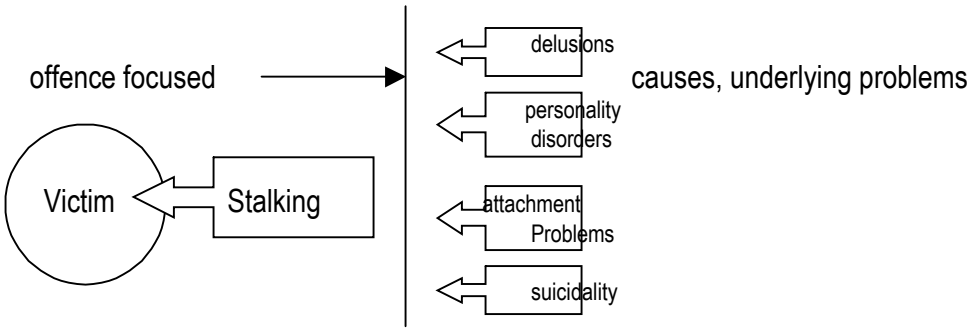
After retrieving her gun the woman attempted to shoot another ex-lover. She was convicted for attempted murder. The assessing psychiatrist later was accused of gross negligence. In the court hearing it turned out that the woman was in treatment due to her mental instability, that she had numerous failed relationships within a short period of time, that she had severe problems with her family and that she had a police record of a former shooting incident – none of this information was considered by Dr. Emilio Modena MD, the assessing psychiatrist.

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:



In stalker treatment, focussing on the offence pattern means, that we consider the stalking behavior per se as the main reason which brings someone to 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). 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 addresse any underlying problems. 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. After the offence focused approach we consider the specific therapeutic challenges related to the individual stalking case.

A. Delusional problems

As therapists in stalking cases we are sometimes confronted with delusional disorders (297.1 DSM-IV, F 22.0 ICD-10), as the following example illustrates:

> *A male accountant was being stalked by a 52 year old female high school teacher for nearly three years. He used to teach the Tango at the local community center and she participated in his class. She then became infatuated with him and started to go to his house ringing the bell, offering him gifts, posting cards, etc. Occasionally he had a conversation with her asking her to respect his privacy, but the next day she was there again. From time to time she also talked to his female partner and her daughter, who both asked several times that she respects their privacy and that she leaves. Finally he avoided being at his own apartment and spent more and more time at his partner's. When he occasionally returned home the door would be festooned with flowers and post-its at the door: «My darling, I miss you so …»; another one: «Don't forget, I love you!». The letter-box was full of cards from her. After he got a restraining order the woman started sending him text messages, e-mails and phoned him up to forty times a day. He then reached his breaking point and sought professional help.*

The diagnostic criteria for delusional disorders (DSM-IV 2000):

A. Nonbizarre delusions of at least 1 months's duration.
B. Criterion A for Schizophrenia[1] has never been met.

[1] Diagnostic criteria for Schizophrenia, A. Characteristic symptoms: two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): (1) delusions (2) hallucinations (3) disorganized speech (4) grossly disorganized or catatonic behavior (5) negative symptoms. Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consists of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other. (DSM-IV, 2000, p. 312)

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.
D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

Specific types include: Erotomanic type: delusions that another person, usually higher in status, is in love with the individual. Others see DSM-IV.

In clinical practice when a delusional disorder is the duty of the treating psychiatrist *to judge what is right and what is wrong, what is true and what is not* (Musalek 2003, p 156). The disorder undermines the social judgement and functioning of the affected person, especially in erotomania. *The patient suffering from delusional ideas is no longer able to decide what he or she wants to do: the delusional convictions move the patient* (Musalek 2003, p. 157). In the therapeutic process a reliable working situation must be established, where those affected feel able to communicate their difficulties and perspectives. Cognitive intervention techniques combined with (low dose) neuroleptic treatment is the method of choice. For the treating therapist it is important to note that delusional disorders are much more prevalent in daily practice than described by clinical based experts. In the case mentioned above the great difficulty is to bring this lady into treatment and provide her with the help she needs.

B. Personality disorders

Personality disorders are described as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, it is pervasive and inflexible, has an onset in adolescence or early childhood, is stable over time, and leads to distress or impairment. The DSM-IV lists 10 different types of personality disorders, based on the predominant personality aspects (301.0 – 301.9 DSM IV, F60-62 ICD-10). The diagnostic criteria for a Personality Disorder according to the DSM-IV:

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
(1) cognition (2) affectivity (3) interpersonal functioning (4) impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance or a general medical condition.

This categorical perspective is enlarged by the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another.

> *Lisa, a patient in her 20ies, contacted the psychiatrist seeking help with an ex-partner who was stalking her. She presented various e-mails from him where he had threatened her and also blamed her for the break down of their relationship. She met him on the internet two years ago. She was the victim of sexual abuse and domestic violence in her childhood and had difficulties coping with life. During the examination it became clear that the man had intended to lead her into prostitution and to be her pimp. According to what Lisa said about her ex-partner it became clear that he has to be diagnosed with a severe personality disorder including anti-social behavior. Lisa was then instructed on how to deal with this situation and to avoid all contact. She was surprised with this intervention because she had assumed that trying to reason with him would be the best approach at dealing with him, which is what she had done over the last two years.*

In accordance with German author Fiedler (2001), the diagnosis of a personality disorder can only be made, when (1) someone suffers under his/her personality traits, (2) when they are relevant for the development of an other psychiatric disorder (e.g. affective disorder, suicidality, etc.), and (3) if the person due to his/her personality problems faces social difficulties (e.g. ethical or legal conflicts).

This case example illustrates the need for legal measures to bring a stalker in treatment; they are certainly not motivated. To be effective, the mandatory treatment should be based either on a police order or be part of the law enforcement investment, and not part of the criminal proceeding per se.

C. Attachment problems

Attachment problems, especially in adulthood, are not yet included into the categorical diagnostic systems in psychiatry. In the DSM-IV they are addressed as relational problems, without receiving the professional attention they deserve. There only exists a diagnosis 313.89 *Reactive Attachment Disorder of Infancy or Early Childhood*, but for adults no diagnostic entity exists. This raises critical philosophical questions about approaches and concepts of current psychiatry; keyword: the neglect of attachment. As stalking is always a relational problem, there is an urgent need to reconsider the understanding of psychiatric problems from Attachment Theory's perspective. For the treatment of stalkers this approach opens a wide range of intervention strategies, as in many cases the attachment problems play a crucial role in its development.

> *A female community support officier volunteer was assigned a man suffering from social difficulties (e.g. assistance in day to day issues). One day he announced that he had found a new appartement just opposite to where she lived. At first the lady was not concerned despite what she had learned in his records. He had always had relationship difficulties and the police had to intervene due to interpersonal violence. Shortly after the man had moved in he started stalking her by phoning her, watching her, ringing her door bell, and following her to the supermarket and alike. Ultimately he forced her into having contact with him. One day, on the way back from the supermarket, when he constantly followed her, she felt so threatened that she went straight away to the police station to report him. She later consulted a psychiatrist and started discussing about what she knows about him. It then turned out, that the man obviously was suffering from severe attachment problems going back into his childhood, never having had constant and reliable relationships with care givers. In her work, the officier volunteer never could imagine that she herself would become his attachment object, and behaved rather naively.*

Attachment interventions are based on a comprehensive understanding of adult inner working models, and their modification through corrective attachment therapy (Levy et al. 2000). In many cases, past traumatic experiences have a deep impact on the development of inner working models (Bowlby 1988), self esteem (Fonagy et al. 2002), and adult relationships (Levy et al. 1998). In the case example of the man, who stalked the community worker, had experienced a very bad childhood – creating severe attachment problems. The community worker was not aware of the risk such a behavior can have in the professional situation. However, attachment problems can never be an excuse for such an unacceptable behavior. To bring this man into treatment would only be possible when it is mandatory.

This example once again illustrate the need of mandatory treatment for stalkers as this man is certainly not motivated to undergo therapeutic intervention voluntarily.

D. Suicidality

Treating psychiatrist must have a comprehensive understanding about treating suicidal patients. In stalking cases, a suicidal stalker can become extremely dangerous. He no longer fears any consequences, neither for himself, nor for others. A thorough suicidal risk assessment is a sine qua non requirement Simon et al. 2006). Approximately one in four stalkers shows suicidal ideations (Mohandie et al., 2006).

In the retrospective analysis of family murder we learn that in two thirds of all cases the murdering was proceeded by stalking (McFarlane et al. 1999).

E. Other

A wide range of other problems can be identified as determinants for stalking behavior, for example courting behavior, revenge, poor social skills, just to name a few. There exists a variety of possible treatment approaches which will help in improving someone's abilities, e.g. social skill training to overcome dating problems.

The offence focussed approach avoids endless debates about the underlying causes, the theoretical foundations of the different hypothesis, and the school-specific treatment modalities. Stalking is considered as an inexceptable complex social interaction between offender and victim; and treatment first aims to stop the stalking behavior, and solving underlying problems in the second step. Of course, the two steps go hand in hand; and its division here is only done for didactic purposes. When stalkers realise, that the treatment is aimed to help them, their motivation to participate increases significantly. To bring them into treatment, specific law is necessary, as their insight and motivation is often not present. It is a therapeutic bias, when the motivation is considered as a precondition for a successfull treatment (Miller et al. 1991). Rather, building motivation should be part of the treatment process.

Conclusion

The phenomenon of violence and aggression in close relationships including violence against children first became a topic in modern medicine, jurisprudence and social sciences in the 1960s. Landmark contributions were Kempe's book «The Battered Child» (1968), the formulation of the PTSD and DID concept in 1980 by the American Psychiatric Association (included in the DSM III); the legislation on marital rape and sexual harassment; and early in the 1990s the implementation of Anti-Stalking Laws and TMU (threat management units) among police forces.

Over the last decades psychiatry has started to deal with interpersonal violence in all forms and has provided treatment approaches firstly for victims, and later for the offenders. Stalking is no exception. Although we can find historical attempts at dealing with stalking cases, this approach was based on the understanding of stalking as being related to an underlying disease – e.g. erotomania. The hypothesis was, that when the medical problems are sufficiently treated, then the stalking behavior will disappear.

After a considerable paradigm shift from the understanding of interpersonal violence as a behavior problem which is not necessarily related to an underlying medical problem, but rather based on social interaction misperceptions (e.g. de-valuating others; see for example De Zulueta 2006), treatment approaches based on offence patterns became available. Stalking like other forms of interpersonal violence range from minor

boundary problems to physical attacks, and even murdering. There is a clear need of therapeutic interventions not only for the dangerous subjects, but also for those committing comparable minor crimes – we should not forget that one model of criminality proposes a learning effect over time, which means when we successfully can intervene in earlier phases we then contribute in a preventive way.

The offence focused treatment offers a pragmatic approach in helping stalkers to deal with their difficulties, often related to attachment problems, delusional disorders, and social skill deficits. The therapeutic approach is based on two avenues of intervention techniques which are provided simultaneously – on one side the therapeutic intervention per se, which is based on cognitive behavioral techniques and on the other side the risk-assessment, always performed as an ongoing process. The stalker treatment requires a close co-operation with other involved professionals, especially the victim treatment providers, and police forces. However, without an Anti-Stalking Law in place, the police has no legal legitimation for taking action.

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