

Resource Document on Stalking, Intrusive Behaviors and Related Phenomena by Patients

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Prepared by the Council on Psychiatry and Law

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I) Introduction and Disclaimer

The doctor-patient relationship should ideally be a collaborative and mutually respectful one. In some instances, however, patients may engage in behaviors that can engender concern and even fear in the psychiatrist involved. When these behaviors are repeated, unwanted, and distressing, we might colloquially refer to them as "stalking." In the midst of a stalking episode, it may be difficult for the psychiatrist to know how to proceed, what steps to consider to protect oneself and what choices to consider to manage the patient-physician relationship. In this document we provide practical guidance for psychiatrists who may face these situations in the course of their work with patients. It was drafted via the consensus of individuals whose practices intersect at the interface of law and psychiatry and represents a range of voices and recommendations. It provides general guidance and is not considered dispositive for any particular response to specific situations. Individual circumstances may require courses of action that differ from those noted in this document.

A) Definitions

The *Violence Against Women Act* of 2005 (Amendment, Stat.108 1902 et seq) defines the phenomenon of stalking as:

"engaging in a course of conduct directed at a specific person that would cause a reasonable person to (A) fear for his or her safety or the safety of others; (B) suffer substantial emotional distress."

From a more clinical perspective, Mullen, Pathe, & Purcell (2000) [hereafter Mullen et al.] define stalking as follows:

“Stalking is those repeated acts, experienced as unpleasantly intrusive, which create apprehension and can be understood by a reasonable fellow citizen (ordinary man or woman) to be grounds for becoming fearful.”

This definition was previously adopted by a consensus group of expert forensic psychiatrists as having practical treatment and risk management utility (Pinals DA 2007). For the purpose of this resource document, the authors also adopt the Mullen et al. definition. We note that no single state legal definition exists and individuals who may be pursuing legal action will need to rely upon their particular jurisdictions for the scope, definition and penalties of stalking offenses.

Finally, for behavior to be considered “stalking,” psychiatrists must necessarily consider what would go beyond what might be acceptable or expected in the course of clinical treatment. They must also consider what goes beyond the usual transference and countertransference reactions of the treating psychiatrist. While aberrant behavior against a psychiatrist is not the norm, psychiatrists do experience unique baseline exposure to disturbed attachment behavior and have specific training related to that behavior. For example, a patient with psychosis on an inpatient unit may call the psychiatrist’s office multiple times in a single day; in those circumstances, the psychiatrist might merely note the behavior and manage it clinically. For the purpose of this resource document, we refer to situations in which the emotional response of the psychiatrist includes reasonable apprehension, fear, and/or distress.¹

II) Epidemiology of Stalking Behaviors Towards Physicians

The incidence of stalking in the general population in the United States varies across studies. This variance can be explained in part by the inconsistency of definitions of stalking and the various populations that have been surveyed (Spitzberg, Cupach 2007). The 2011 National Intimate Partner and Sexual Violence Survey (n=12,727 across all 50 states) estimated that 15.2% of women and 5.7% of men have been victims of stalking during their lifetime (Breiding et al. 2014). These rates were significantly higher than a prior study, which raised the question of whether lifetime prevalence of stalking victimization in the United States was/is on the rise (Tjaden, Thoennes 1998). The majority of stalking victims are women (80-90%) and the vast majority of all stalking perpetrators are men (80-90%) (McCann JT 2001). Among female victims, the vast majority of stalkers were male. Among male stalking victims, the perpetrators were equally likely to be male or female.

Only a few studies have examined the risk of being stalked by physician specialty. One Canadian study found that the rate of stalking victimization is highest for the following three specialties: Psychiatry (26.5%), OB/GYN (16.3%), and Surgery (15%). Male and female physicians were equally likely to be stalked and 62% of the stalking incidents lasted less than 12 months (Abrams, Robinson 2011). Another study (Abrams, Robinson 2013) surveyed 1190 physicians and found psychiatrists represented 9.8% of all respondents and represented 21.8% of all physicians stalked (second only to General Practitioners). A survey of 2,585 psychiatrists in the United Kingdom indicated a 21.3% lifetime prevalence of having been stalked (Maclean et al 2013). Finally, in a study of over three hundred psychiatrists working in a large mental health organization in London, 22% reported themselves as having been a victim of stalking or harassment by a psychiatric patient (McIvor et al. 2008). In this survey, male and female psychiatrists were equally likely to have been stalked.

¹ Cyberstalking, understood as the use of internet, email, social media or other digital technologies to harass or stalk another person is important but sufficiently complex that it is beyond the scope of this paper.

The characteristics of patients who stalk their psychiatrists are not fully elucidated or even consistently captured. A 2011 study yielded data showing that the average age of stalkers of psychiatrists in the UK was 40 years old and there was an even gender distribution of stalkers. With respect to employment status of the stalkers, 51% were thought to be unemployed, 19% were employed full time, 5% were retired, and 4% were students (Whyte et al. 2011). Mclvor and colleagues conducted a survey involving 324 psychiatric consultants and psychiatric trainees in London and their experiences being stalked. Of the respondents, 34% thought that their stalkers had a mental health diagnosis. Results also suggested that 59% of stalkers were male, and 39% had a personality disorder (Mclvor et al. 2008). In one 1998 study of an inpatient population who had stalked, threatened, or harassed hospital staff after discharge, the offenders were more likely to suffer from a personality disorder or a delusional disorder than a control group of other discharged patients (Sandberg et al. 1998). The main forms of harassment reported by health practitioners “across all studies were repeated telephone calls, unwanted approaches, loitering, correspondence and e-mail, property damage, and unsolicited gifts.” (Pathé M, and Meloy JR 2013). However, threats to harm, physical and sexual assaults and malicious complaints to licensing boards were not uncommon (Pathé M, and Meloy JR 2013).

III) Interventions/Management

Below, we discuss a variety of potential interventions when it appears that stalking or other serious harassment behaviors have occurred. We particularly highlight the importance of taking appropriate measures for one’s immediate personal safety, and seeking multi-disciplinary consultation as soon as possible. However, the considerations discussed here are not comprehensive. Stalking scenarios are often complex and ever-changing, and a one-size-fits-all approach is not possible; further research is needed regarding the management of stalking behaviors and the effectiveness of specific interventions (Mullen et al., 2006; Binder, 2006; Mackenzie et al., 2011). Therefore, the use of sound clinical judgment with regard to managing the stalking patient and having the flexibility to adapt as a case evolves remains critical (Mullen et al., 2006; Binder, 2006; Pinals et al., 2007; Mackenzie et al., 2011; Carr et al., 2013).

A) Immediate Safety

When psychiatrists are concerned about being stalked, they must consider immediate steps for their own safety and the safety of others who might be at risk, which might include warning others in the workplace (Manca, 2005) or family members. This is particularly important if specific threats have been made.

Immediate safety measures might include:

- Contacting the healthcare settings’ security services or local law enforcement,
- Activating body alarms if worn and indicated,
- Following any established safety guidelines for relevant high-risk scenarios (e.g., active shooter, bomb threats, etc.), and
- Considering a multi-disciplinary consultation.

Other practical safety measures might include:

- Parking near security,
- Memorizing emergency numbers,

- Keeping a cell phone readily available,
- Scheduling sessions at a time when colleagues are also seeing patients in the office suite or clinic,
- Forming a safety network among colleagues, and
- Planning an escape route (Manca, 2005; Pinals et al., 2007).

B) Prevention and Intervention

Carr and colleagues outline a model of primary, secondary, and tertiary prevention for both the individual psychiatrist and the healthcare setting (e.g., university, hospital, private clinic, etc.) (Carr et al., 2013). Primary strategies can be routinely incorporated into clinical care; secondary strategies may be considered when the psychiatrist has concerns about patient behavior, such as when expected boundaries are tested; and tertiary strategies become important when stalking behaviors may include actual threats to cause harm or actions resulting in harm.

Examples of primary prevention measures include:

- Providing detailed information at the outset of treatment regarding how therapy will work, the frame of the therapeutic setting and context, and the importance of collaboration in a way that helps maximize a sense of safety for all parties,
- Minimizing one's online presence (e.g., social media). This particularly applies to personal information, such as one's private phone number, home address, details about personal or family schedules, or even online photos that might easily identify these details,
- Using post office boxes and answering services, and
- Becoming familiar with telephone services (e.g., the procedure to block caller ID when making outgoing calls from a cell phone) (Manca, 2005).

Periodic reviews of basic security measures at home and at work are also important. These measures could include:

- Checking the proper functioning of any locks, alarm systems, motion sensors, and security monitors,
- Training video cameras on entryways and having peepholes on office or clinic doors (Manca, 2005),
- Participating in self-defense classes (Pinals et al., 2007),
- Consulting with private security services or local law enforcement for specific safety strategies (Pinals et al., 2007).

While outside the scope of this document, psychiatrists may also consider consulting with hospital or private cyber security experts.

Examples of secondary measures that might be taken by psychiatrists include:

- Providing and seeking supervision and consultation as soon as possible in a potential escalating situation and informing other members of the patient's treatment team,
- Thoroughly documenting boundary violations, problematic behavior, and attempted interventions.

Finally, examples of tertiary measures that might be taken by psychiatrists include:

- Seeking consultation with experts in behavioral threat assessment and management (see “Consultation” below),
- Participating in ongoing risk assessment, especially at critical junctures such as anniversaries and court dates, which may elevate the potential for the stalker to become violent, and
- Careful consideration of whether, when, and how to terminate patient care and provision of thoughtful referrals (of the patient) to an appropriate provider (see “Legal and Ethical Issues” below) (Carr et al., 2013).

A special note about boundary-setting: in general, in any therapeutic relationship, setting firm limits and establishing clear boundaries is important (Manca, 2005). Psychiatrists should examine boundary testing by patients with the possibility that they may progress to stalking. If a patient violates expected prosocial behaviors and there is a specific concern for stalking behavior, the psychiatrist may consider sending one clear, unambiguous message to the patient to change this behavior (Sandberg et al., 2002; Pinals et al., 2007; Mclvor et al., 2008). However, this approach can require a more nuanced consideration of when and whether to do so. Caution related to this communication is advised because this may escalate the behavior and increase the risk of retaliation from the stalker in some situations (Sandberg et al., 2002; Pinals et al., 2007). After a careful weighing of the facts, a decision to “do nothing” may be as impactful and helpful as proactive measures, but each situation requires individualized planning and direction. Also, victims or identified stalking targets must often make their own decision (preferably with support and guidance) as to what intervention, if any, to take, early in the course of the stalking behavior. Regardless, if the patient’s behavior persists after reasonable attempts at limit setting, the psychiatrist should try to avoid any direct subsequent engagement with the patient until consultation has been sought (Mclvor et al., 2008) (See “Consultation” below).

C) Consultation

Seeking consultation, particularly from a multi-disciplinary team, is one of the early steps a psychiatrist should consider in situations involving stalking. Even for experienced psychiatrists, getting another perspective about their level of concern (e.g., “Am I overreacting or underreacting?”) can be very helpful. It is also important to acknowledge that each consultation requires a risk assessment and that the facts can evolve, especially as new information about a case becomes available. Thus, it can be helpful to have a consultant available for the duration of the stalking situation, which may be brief or extend for years. The specific make-up of the multi-disciplinary team may vary, but often includes law enforcement, hospital security, legal counsel, forensic psychiatric experts, and other hospital or administrative and personal victim supports.

Depending on the setting, a hospital or university may have a threat management team or a forensic psychiatry service (Binder et al., 2017) that can be particularly useful in scenarios that take place in an institutional context. In a private setting, psychiatrists may consider contacting the nearest university’s forensic psychiatry program, professional organizations like the Association of Threat Assessment Professionals (ATAP), or local law enforcement that has specialized services (e.g., San Diego County District Attorney’s Stalking Unit).

Questions that are commonly asked of consultants beyond violence assessment instruments are:

- How dangerous is the stalker?
- How can the behavior be stopped?
- How do I protect myself?
- Will the behavior stop, or get worse?
- If [the behavior] stops, is it going to come back again? (Binder, 2006; Mackenzie et al., 2011).

While further research is needed regarding the management of stalking behaviors and the effectiveness of specific interventions, (Mullen et al., 2006; Binder, 2006; Mackenzie et al., 2011), a multi-disciplinary consultation approach can systematically assess prevention and risk management strategies. For example:

- Community law enforcement may have seen many stalking cases, have experience or even actuarial knowledge about stalking behaviors, easier access to legal records (e.g., court documents) that could be useful in risk assessment, and understanding of local practices and enforcement regarding anti-stalking laws (Mullen et al., 2006; Binder, 2006),
- Hospital security can help plan on-site safety measures, and
- A private attorney, hospital legal counsel, and/or attorney from a malpractice insurance provider can provide input regarding local criminal stalking laws and about privacy laws related to the release of medical records and pursuit of criminal charges related to one's patient.

A forensic psychiatric team can help determine what types of risk assessment (e.g., HCR-20, SAM, or RSP [Carr, Goranson, & Drummond, 2013; Binder, 2006]) and management options (e.g., psychotherapeutic who, medications, etc.) are reasonable (Mackenzie et al., 2011) for the patient who remains in the care of the psychiatrist or in the care of other psychiatric personnel. A forensic team may also help balance relevant clinical and legal considerations (e.g., confidentiality, duty to third parties, termination of patient care, impact on therapeutic relationship, etc.). Furthermore, a clinical forensic psychiatric consultation service, especially within the same institution, may not require patient consent to review protected health information (though each institution may have unique policies that should be reviewed prior to accessing a patient record).

D) Mental Health Counseling

Psychiatrists who are being stalked may also consider seeking personal mental health counseling. Situations involving stalking can be intense, anxiety-provoking, and potentially lengthy (on average two years) (Carr, Goranson, & Drummond, 2013; Mullen et al., 2009). Though further research is needed on the impact of stalking among physicians, in a questionnaire completed by 274 psychiatrists in Ireland, of those who were stalked (n=69), 85% reported suffering psychological distress as a result of their experience (Nwachukw et al., 2012). Another survey of 1190 physicians, including 117 psychiatrists (Abrams and Robinson, 2013) found feelings of anger (73.8%) frustration (73.1%), anxiety (69.7%), fear (67.6%), helplessness (44.8%) and loss of control (52.4%). A UK study of 10,424 psychiatrists with 2,585 responses found a variety of impacts on psychiatrists, including feeling anxious and afraid (80.65%), having difficulty sleeping (52.19%) and ceasing to enjoy life's enjoyment (11%) (Whyte et al. 2011). Regardless of the basis for the stalking behaviors, the consequences "personally and professionally, can be disruptive and potentially devastating" (MacKenzie et al., 2011).

Many victims of stalking may feel or actually be alienated, blamed, and criticized by supervisors and colleagues (Mackenzie et al., 2011; Carr et al., 2013). In a qualitative U.K. study of 2,585 psychiatrists,

respondents described variability of support from supervisors, colleagues, and law enforcement; some respondents felt very well supported, and others encountered a dismissive attitude that being stalked is inevitable for psychiatrists. Those who received help experienced less distress than those who did not (Macleane et al., 2013).

E) Documentation

Detailed documentation of a patient's stalking behavior toward the psychiatrist or staff is useful for both future legal interventions as well as behavioral management. Victims of stalking are advised to maintain detailed records of any communication attempts on behalf of the stalker, such as emails and phone calls, including dates, times, recordings, and fear about safety (some stalking laws are based on the victim's sense of fear) (Manca 2005). Whether to keep such detailed records separate from the official patient medical record can be complex, and psychiatrists should seek further advice (e.g., from legal counsel, administration, and supervisors) about which details should be part of the medical record and which should be kept as a separate file. In general, clinically relevant information, such as behaviors (e.g., gifts, boundary testing, breaches of privacy etc.), risk assessments, diagnoses, interventions, and issues surrounding termination, can be important to document in the medical record, especially to communicate to the treatment team or other providers involved in the patient's care.

F) Civil Protection Orders

Protection orders are also known by a variety of other names, including restraining orders (Benitez et al., 2010) and intervention orders (Mackenzie et al., 2011). Though the U.S. Interstate Stalking Punishment and Prevention Act of 1996 established that protection orders issued in one state are enforceable in other states (Benitez et al., 2010), the effectiveness of protection orders can vary greatly across jurisdiction. For example, some states' protection orders are designed for specific types of relationships such as domestic or interfamilial violence only whereas other states' orders can be more expansive (Knight, 2014). Moreover, the utility of protection orders is debated and may not be helpful in every stalking scenario as they may fail to protect the potential victim, have high rates of violation, may provide a false sense of security, or even exacerbate the stalking behavior (Ostermeyer et al., 2016). Police and court responses to protection orders may vary considerably since interpreting the point at which patterns of behavior cross the legal threshold and become criminal can be complicated (Mackenzie, et al., 2011).

Nonetheless, while they may not necessarily deter stalking behavior, protection orders may give law enforcement leverage to take the stalker into custody (Binder, 2006). Thus, consultation may be particularly useful to draw on experiences, knowledge of the perpetrator's prior response to such orders, and any available scientific literature to make recommendations. For example, in a review of 15 publications, factors such as timing, potential escalation of behaviors, victim characteristics, perpetrator characteristics, abuser-victim relationships, and the context of the legal system were useful to consider in determining whether a protection order can be useful (Benitez et al., 2010).

Some additional considerations with protection orders are that they may be more effective earlier than later (Ostermeyer et al., 2016; Pinals, 2007), a stalker's reaction to any previous protection order may be useful to guide decisions, and, if agreed to be ordered, the psychiatrist must make a commitment to report all violations to the appropriate authorities (Pinals et al., 2007). Overall, even if protection orders are in place, they do not replace other personal protection and safety measures. It can be helpful to work closely with one's local law enforcement leadership in the jurisdiction where such a protective

order might be issued so that they are aware of the protection order and the psychiatrist has points of contact in case of an untoward situation.

IV) Healthcare Setting Obligations

Organizations and businesses generally have a legal and ethical responsibility to ensure workplace safety. Unfortunately, many healthcare settings and organizations do not have well-defined procedures on how to handle stalking situations (Carr, Goranson, & Drummond, 2013). First and foremost, organizations should strive to create and maintain work environments that are conducive to persons reporting concerns and receiving supports. In addition, there is a progressive escalation of interventions which organizations might undertake.²

Examples of primary prevention measures that might be taken by institutions include:

- Educating providers around issues such as the importance of setting and maintaining appropriate boundaries in a therapeutic relationship even when those boundaries are challenged or tested;
- Ensuring that healthcare providers are educated about community contacts and support, such as law enforcement, so as to be able to readily seek assistance for any concerning patient behaviors, and
- Establishing and educating staff about policies and procedures with regard to stalking behaviors by patients.

An important consideration for risk management personnel in universities, hospitals, and healthcare settings is what policies and/or procedures are needed to handle situations involving stalking. These types of protocols would be separate and distinct from a sexual harassment type protocol or policy. A stalking-related protocol or policy would include safety measures, expected legal responses, and a mechanism to provide staff with emotional support, resources, and multi-disciplinary consultation (McIvor et al., 2008). Provisions for staff to take a leave of absence to address any psychological distress and to tend to practical matters, such as court appearances, may be necessary. It is also important for administrative supports to be prepared to step in to manage communication with the patient and assist in the transfer of care when clinically appropriate (Mackenzie et al., 2011).

The healthcare setting may additionally consider a standardized debriefing with staff - with appropriate discretion regarding victim and patient privacy - regarding what patterns or conduct has occurred, how the clinic responded, what risks may persist, and what is needed from the rest of the clinical staff. Creating this culture and establishing related policies can provide an opportunity to educate staff about preventative measures, such as boundary and transference issues, and violence risk assessment and management resources. On a practical level, creating a collegial atmosphere that facilitates the disclosure of problematic patient behavior may allow earlier recognition, assessment, and treatment of the potential stalker, while also protecting co-workers and other clients (Mackenzie et al., 2011).

V) Legal and Ethical Issues

² As already noted, this document focuses on safety pertaining to patients as potential stalking perpetrators, and does not address workplace safety related to co-workers or domestic partners who may pose separate risks in a workplace setting.

Legal and ethical issues, such as concerns regarding breach of confidentiality and abandonment when terminating patient care, often arise when psychiatrists are concerned about being stalked. Psychiatrists may be in a “double bind,” in which taking appropriate steps may result in a violation of confidentiality or even result in negative consequences for the patient (Carr, Goranson, & Drummon, 2013). Seeking consultation, and proactively establishing appropriate procedures in healthcare settings for such situations, can help address some of these concerns. In some settings, for example, psychiatrists may establish a zero-tolerance termination policy (Manca 2005), though legal and risk management guidance for such considerations is strongly advised.

Specific administrative strategies for termination and referrals should also be considered, such as, if indicated, provisions for clear communication to the patient that any contact with the previous psychiatrist (who was stalked) may be criminally prosecuted. If a termination letter is sent, it should be by certified mail and include referrals to another professional, and might be better to come from the administrative director or clinic rather than the psychiatrist who was stalked (Pinals et al., 2007). However, there should also be a careful determination of what if any final contact should be generated from the psychiatrist with clear instruction that leaves no room for ambiguity. If the patient is being referred to an out-of-system provider, then ethical and legal transfer of information is important. The psychiatrist (who was stalked) should develop a strategy to manage any future contacts - for example, one way to address the issues is that once the patient care has been terminated, it might be prudent for the psychiatrist who was stalked to not respond directly to the ex-patient’s future contacts. Instead the hospital risk management division should send a clear and polite letter stating that it is hospital policy for the psychiatrist not to respond to the ex-patient, but to address the ex-patient’s needs through the hospital system (e.g., a request for a release of records). The psychiatrist who will be taking on the treatment of the patient should also carefully consider unique challenges in these situations, such as “stalking by proxy,” which in this case reflects when the patient passes notes or communication to their previous psychiatrist through their new psychiatrist (Carr et al., 2013).

VI) Special Considerations involving Medical Students and Psychiatric Residents

Given the higher prevalence of psychopathology in individuals who stalk medical professionals (McIvor, Petch, 2006) and the higher prevalence of stalking victimization amongst psychiatrists as compared to other physicians (Abrams, Robinson 2011), trainees in psychiatry, from medical students in clinical clerkships to fellows in subspecialty fields, might be at risk for becoming stalking victims in these contexts. To these authors’ knowledge, there have been no published reports or protocols about how psychiatry residency training programs approach this issue.

Unlike practitioners already in independent practice, psychiatric students and trainees may not be as skilled at picking up any early warning signs of stalking. Stalking may escalate from repeated phone calls to showing up to appointments outside of a scheduled session (Lee, Missett 1994). Such behaviors may be minimized as part of the patient’s psychopathology and not reported quickly to a supervisor. There may be a sense, too, that the professional role offers protection when care is delivered objectively (MacKenzie et al., 2011). Trainees who are just learning about the boundaries of a treatment relationship may inadvertently encourage behavior that may lead to stalking. For an example, a boundary crossing (aimed at enhancing the therapist’s treatment efforts), such as giving a hug instead of a handshake at the end of a particularly difficult session could be misinterpreted by a particular patient (Marshall, Teston 2008).

The American College of Graduate Medical Education (ACGME) Common Program Requirements stipulate that accredited residency programs monitor residents' well-being, evaluate workplace safety data, and address "the safety of residents and faculty members."³ They also have requirements about supervision and progressive independence over the course of the residency. The ACGME makes clear that "at each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location (ACGME, 2019)." The presence of a readily-available and approachable supervisor is a critical component in reassuring trainees that they are not alone in their work, that they have a safe space in which to discuss the dynamics of a wide variety of therapeutic relationships, and that they have someone to whom they can go when they have concerns. Unfortunately, many supervisors themselves are unfamiliar with how to best to handle, or possibly even identify, a stalking situation. In addition, trainees may not report problematic behavior to their supervisor for fear of being perceived as a failure in the treatment relationship, shame, or a misplaced sense of a duty to treat the patient despite risk to the resident (Appel, Kleinman 2012).

Supervisors should be educated about steps to take in the event that a supervisee reports concerning patient behavior. Program directors should have a protocol in place that addresses such issues by bringing in additional faculty supports, consulting with in-house forensic psychiatrists or even consulting with other programs, determining when to notify law enforcement and the risk management division of the resident's training institution, and how to prioritize resident health and safety in the context of the stalking situation. Residents should also be instructed on careful risk assessments and warning signs about problematic behavior to ensure their safety early as part of preventive strategic planning.

Recommended Elements of a Stalking Prevention and Response Program for Trainees

Examples of measures that might be taken by institutions include:

- Didactics early in training regarding boundary crossings, boundary violations, patient stalking and other behaviors are important to increase knowledge about such issues. Didactics should include:
 - Definitions of Stalking
 - Clear guidance indicating that psychiatrists are responsible for managing transference and boundary issues as well as safely navigating patient relationships, and as such they may need assistance when their capacity to cope or manage is outweighed by their concerns and fears related to patient behavior.
- A clear protocol about potential notifications which should include:
 - Direct supervisors (senior resident, chief resident, or attending resident),
 - Program Directors
 - Hospital Safety Officer and Security (if available) to consider security measures for the resident while they are in the hospital,
 - Multidisciplinary threat management team if one exists (including the police, who can do a search regarding that individual's legal history),
Institutional police who may be able to research the perpetrator's legal history, put an institutional restraining order in place, and contact the local police department in the jurisdiction of the resident's home to provide extra protection.

The recommendations above with regard to Consultation, Mental Health Counseling, Documentation and Protection Orders may be equally applicable to scenarios involving psychiatrists in training.

Resources for the Patient

A final issue of paramount importance is how to continue providing care in some way for the patient or how to safely refer the patient to the next psychiatrist who may need information as to the reason for the transfer. There is a fiduciary duty on the part of the physician that needs to be balanced against concerns for their safety. Depending on the location where the stalking is occurring, several options for patient care include transferring to a different provider in the same location (but possibly in another building) or transferring the patient to another provider altogether. These can also be items for consideration in Consultation.

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