The Assessment and Management of Stalking Perpetrated by Clients Against Their Counselors

Jennifer E. Storey

University of Kent

And

Stephen D. Hart

Simon Fraser University and the University of Bergen

Author Notes

The authors wish to thank the British Columbia Association of Clinical Counsellors for their support and cooperation. Also acknowledged is the work of Mary Nguyen, Allison Harasymchuk, Samantha Herbert, and Stephanie Fowler in transferring and cleaning the data. Jennifer E. Storey was supported by a Postdoctoral Fellowship from the Social Sciences and Humanities Research Council of Canada. The opinions expressed herein are those of the author and do not necessarily reflect those of any other person or agency. Portions of the data reported herein were previously included in the author's unpublished doctoral dissertation Storey (2012).

Address correspondence to Jennifer E. Storey, School of Psychology, Keynes College, University of Kent, Canterbury, Kent, UK, CT2 7NZ, email: j.storey@kent.ac.uk

Abstract

Mental health professionals are at heightened risk of stalking victimization, however minimal research has examined empirically supported risk factors for stalking and the efficacy of risk management strategies. 346 counselors were surveyed, and the present study focuses on the 7% (n = 23) who had been stalked by clients. Results describe the characteristics of stalking, perpetrators and victims and the perceived efficacy of management strategies employed. Stalking behaviors tended to be of lower severity. Common perpetrator risk factors included relationship problems, anger and obsession. Victim vulnerabilities were identified, where many victims engaged in behavior considered inappropriate in response to stalking. Victims often encountered problems coping with victimization due to inadequate access to resources. Results indicate that risk management plans must be individualised and highlight ways that mental health professionals can and would like to be protected from stalking.

Keywords: criminal harassment; mental health professional; violence risk assessment; violence risk management; violence in the workplace

The Assessment and Management of Stalking Perpetrated by Clients Against Their Counselors

Awareness of, and empirical research on stalking has developed substantially since stalking was first criminalized in 1991 (Tjaden, 2009). Stalking is now recognized as a criminal offence in many countries, and the repeated and unwanted contact that characterizes stalking is understood as a form of violent victimization (International Legislation, 2014). In Canada, stalking is called Criminal Harassment and falls under s. 264 of the *Criminal Code*. Lifetime prevalence rates of stalking in Western populations vary (2%-15%; Whyte et al., 2011), in Canada, they are approximately 4% for women and 2% for men (Canadian Centre for Justice Statistics, 2005). Rates of stalking not equivalent for all individuals, mental health professionals (MHPs) are at heightened risk. A review by Galeazzi and De Fazio (2006) of MHPs from multiple countries, found prevalence rates of 10%-20%. The enhanced risk posed to MHPs has led to a call for greater victim protection (McIvor & Petch, 2006; Whyte et al., 2011). However, despite increased stalking research, studies focused on victim protection are limited.

A form of violence prevention found to reduce rates of victimization is violence risk assessment and management (Belfrage et al., 2012). Violence risk assessment and management refers to "the process of evaluating individuals to (1) characterize the risk they will commit acts of violence and (2) develop interventions to manage or reduce that risk" (Hart, 2001, p. 14). Two violence risk assessment instruments exist specifically for assessing risk in cases of stalking, the *Guidelines for Stalking Assessment and Management* (SAM; Kropp et al., 2008) and the *Stalking Risk Profile* (SRP; MacKenzie et al., 2009). Both instruments guide evaluators in the assessment of empirically derived risk factors for stalking and identification of management strategies that will mitigate those risk factors, a method known as structured professional judgement. Risk factors for stalking have been identified related to stalking behavior (i.e., the individual

behaviors that constitute the stalking campaign), and the characteristics of the perpetrator and victim. A minority of these risk factors have been examined in cases where MHPs are the target of stalking.

With respect to the nature of the stalking behavior, studies have shown that stalking behavior directed at MHPs typically persists for 5 to 10 months but can continue for as long as 10 years (Galeazzi et al., 2005; Purcell et al., 2005). The most common stalking-related behaviors include unwanted communication, approach behaviors and direct contact (Galeazzi et al., 2005; Purcell et al., 2005; Whyte et al., 2011). Violent threats occur in about 25% of cases and physical violence is uncommon (2.5%-10%) (Galeazzi et al., 2005; Kivisto et al., 2015; Purcell et al., 2005; Whyte et al., 2011).

Perpetrators who stalk MHPs are often single and unemployed (Galeazzi & De Fazio, 2006). Mental health problems are common, with the most common diagnoses being Cluster B personality disorders, psychotic disorders and mood disorders (Galeazzi et al., 2005; Gentile et al., 2002; Kivisto et al., 2015; Purcell et al., 2005; Romans et al., 1996). Elevated rates of child abuse and recent losses or stressors are also common (Gentile et al., 2002; Romans et al., 1996). The presence of diagnoses and stressors may increase contact between potential stalkers and MHPs as they seek assistance for their problems.

Also key to the assessment of risk is the identification of perpetrator motivation (MacKenzie et al., 2009). Perpetrator motivation provides information on the function of stalking for the perpetrator as well as guidance on how the course of stalking will unfold and how the perpetrator will respond to intervention (MacKenzie et al., 2009). MHPs most often perceive stalking behaviors to be motivated by resentment and infatuation or intimacy seeking (Kivisto et al., 2015; Purcell et al., 2005; Whyte et al., 2011). Other motives, described by 17% of the MHPs

surveyed by Purcell and colleagues (2005), include boredom, loneliness, boundary testing, and the intrusion of the client's relatives who were seeking to influence therapy.

Most limited, are studies examining vulnerabilities among MHPs that place them at risk of stalking victimization. It has been suggested that victimized MHPs tend to engage in minimization and denial to feel secure while continuing to treat clients engaging in stalking (Sandberg et al., 2002). MHPs are also unlikely to report stalking to police (9%-25%) (Purcell et al., 2005; Romans et al., 1996). These vulnerabilities may be prevalent due to professional characteristics. MHPs may believe that their training equips them to assist stalkers, and so fail to recognize risk or report stalking. MHPs may also be reluctant to cause harm to a client, whom they were once ethically bound to help. Evidence indicates that MHPs also fear co-workers will judge them as unskilled if they reveal stalking victimization by a client (McIvor & Petch, 2006; Mullen et al., 2009; Romans et al., 1996; Storey, 2016).

The management of stalking perpetrated against MHPs has also received limited empirical investigation and perhaps as a result MHPs receive little to no training on how to manage stalking by a client (Ring, 2018). Some researchers have, based on case studies or practical experience, recommended guidelines or strategies for MHPs to manage stalking risk (e.g., Dubin & Ning, 2008; Kivisto & Paul, 2017; Lion & Herschler, 1998; Meloy, 1997). In addition, a comprehensive but untested model of management has been forwarded by Carr et al. (2014), that considers the challenges faced by MHPs such as boundary violations and transfer of care. The authors specifically suggest education for MHPs in, and the use of, violence risk assessment instruments like the SAM and SRP to facilitate the ongoing assessment of risk and management of stalking if being stalked. A handful of studies have examined the frequency with which management strategies are employed in cases of stalking, however only a few of these

have surveyed MHPs. For example, Romans and colleagues (1996) reported the frequency with which counselors made particular life changes as a result of being stalked, finding that obtaining an unlisted phone number (25%) and calling police (9%) were the most common strategies, but only employed in the minority of cases. Even fewer studies have investigated the efficacy of management strategies used my MHPs, and only one of those studies reported results for stalking alone. Sandberg et al. (2002) surveyed hospital staff about the efficacy of management strategies to combat stalking, threatening and harassment behavior finding the following strategies to be perceived as effective by all who reported using them: notifying the police or hospital security, seeking consultation from an expert, having the patient arrested or taken into legal custody, and obtaining a restraining order against the patient. Results were not presented for stalking alone. Only Kivisto et al. (2015) have investigated the perceived efficacy of stalking management strategies used by MHPs. Stalking management strategies consistently rated as making the situation better included, obtaining a restraining order, increasing home security, changing home phone number, changing work address, seeking assistance from family or friends, and from a lawyer or a professional indemnity provider. Four strategies, confronting the client, increasing workplace security, seeking assistance from colleagues, and from police, were most often rated as making the situation better but sometimes made it worse. Two strategies, making a referral and hospitalising a client, were rated as making the situation better and worse with equal frequency.

Current Study

Violence risk assessment is a neglected area of MHP safety (Dubin & Ning, 2008; Kivisto et al., 2018). Empirically derived risk factors for stalking remain underexamined in this group and this is particularly true for victim vulnerability factors. Further, little is known about

how and why MHPs make decisions about risk management and the extent to which the management strategies employed are perceived as being effective. Such information is critical for preventing violent victimization and identifying solutions for victimized MHPs who face heightened risk and additional barriers to managing client perpetrated stalking. The aim of the present study was to uncover information related to stalking risk and management that could decrease victimization. Specifically, it investigated the risks posed to MHPs by examining empirically derived risk factors for stalking and the use and perceived efficacy of risk management strategies. The following research questions were investigated: (1) what are the characteristics of stalking, perpetrators and victims in cases where MHPs are stalked by their clients? (2) what risk management strategies are employed? and (3) what management strategies are perceived to be effective in ending the stalking behavior?

Method

Procedure

Participants were recruited from the British Columbia Association of Clinical Counsellors (BCACC) (membership 2,033 counselors). Counselors were selected as the MHP group of interest for this study because they represent a diverse group with respect to their education, practice and clientele. BCACC members must have: a master's degree, completed six counselling courses and 100 hours of clinical supervision. They provide treatment for a range of issues including mental health problems, grief, relationship problems and life transitions. Counselors have also been understudied compared to other MHPs (e.g., psychologists and psychiatrists) with respect to stalking. Only one study by Romans and colleagues (1996) examined MHPs working in a counseling center. Further, the BCACC was motivated to obtain information that would assist members, given some recent stalking incidents. Ethical approval was obtained from the BCACC and Simon Fraser University.

BCACC members were first made aware of the survey in an article published in their association's magazine. Subsequently, members were asked to take part in a survey via email; two reminder emails were distributed. Participation was voluntary and anonymous; the BCACC had no knowledge of which members participated. A total of 346 counselors responded to the survey, a response rate of 17%. Upon completion of the survey, respondents were thanked and given references to reading material on the stalking victimization of MHPs. Access to free and confidential support, provided by a counselor with experience related to stalking, was offered to respondents who were distressed or in need of assistance.

Materials

An anonymous online survey format was used to increase disclosure, since previous studies indicate that MHPs may feel embarrassed about being stalked by their clients (McIvor & Petch, 2006; Romans et al., 1996). The survey, developed using Remark Web Survey 3, took approximately one hour to complete for respondents who had been the victim of stalking and 20 minutes for those who had not.

Participants self-identified as victims of stalking based on the SAM definition, "Stalking is the unwanted and repeated communication, contact, or other conduct that deliberately or recklessly causes people to experience reasonable fear or concern for their safety or the safety of others known to them." (Kropp et al., 2008, p. 1). A total of 23 (7%) respondents identified as victims of stalking by a client. Those 23 victims are the focus of the present study. It should be noted that two respondents described being stalked by clients elsewhere in the survey but did not endorse the definition and thus did not answer questions about their victimization. For clarity and conciseness, survey respondents who were stalked will be referred to as *victims* and those individuals who engaged in stalking will be referred to as *perpetrators*.

Victims were asked closed and open-ended questions about the nature of the stalking, perpetrator risk factors, their own vulnerability factors, warning signs of stalking and the risk management strategies they used. Some questions included close-ended options with space for an open-ended response. For three participants, the closed and open-ended responses to one question did not match. In all three cases the close-ended response was altered to reflect the open-ended response given (which was clear and detailed) as it was assumed that the survey question was unclear and had thus caused the discrepancy in response.

Risk factors for stalking were defined as per the SAM. Table 1 presents the three SAM domains and their 10 respective risk factors. Victims who had been stalked on more than one occasion, were asked to respond to the survey questions based on the most serious episode of stalking they experienced. Victims who had been stalked by more than one perpetrator at the same time were asked to respond based on the primary perpetrator, typically the individual who committed most of the stalking behaviors.

Victims were guided in rating each risk factor via instructions taken from the SAM manual and a short scoring example. The SAM was only used as an empirically based method upon which to guide self-report and query relevant risk and vulnerability factors. There was no expectation that victims could complete the SAM or use it as a violence risk assessment instrument. Victims identified each risk factor as having, (1) evidence present; (2) some evidence present, or; (3) no evidence present. These responses represent the commonly used structured professional judgment ratings of *Present, Possibly or partially present, and Absent.*

Two variations were made when factors in the SAM's Victim Vulnerability domain were queried, in recognition of that fact that self-analysis might be difficult and self-disclosure unlikely in this context. First, five Victim Vulnerability items were removed (V5 *Problems*

caring for dependent, V6 *Intimate relationship problems*, V7 *Non-intimate relationship problems*, V9 S*ubstance use problems*, and V10 *Employment and financial problems*). Items were removed because they might have unnecessarily upset victims and because it is unlikely that responses would have been provided. Second, the remaining five Victim Vulnerability factors were queried using two questions for each for each item. Questions were derived from the SAM manual to capture defining characteristics of the items. For example, one of the questions posed for V2 (*Inconsistent attitude toward the perpetrator*) was "Did you ever blame yourself for the perpetrator's behavior, or think that you were exaggerating the seriousness of the stalking?" (p. 47). Affirmative answers to either or both questions resulted in the item being scored as present.

Additional questions were posed regarding perpetrator motivation, mental health and distress. Counselors are not qualified to make psychiatric diagnosis in British Columbia and therefore, where aware, reported diagnoses made by other MHPs. Victims were also asked to report on factors that preceded the stalking, specifically what they thought might have precipitated the stalking and what warning signs might have signalled that stalking behavior was imminent.

Victims were then asked to 'list the strategies that they implemented to try to deter the stalker' in chronological order while also indicating if each strategy was 'helpful' or 'unhelpful'. Specific questions were posed about the use and perceived efficacy of informing police and co-workers about the stalking as well as whether 'changes to practice as a result of the experience' had been made. Sources of support were queried, asking 'who provided the most assistance in managing' or 'handling the adverse effects' of stalking as well as what support they 'wish had been available to them but was not' and would 'recommend to other victims'. Questions about

what they 'thought caused the perpetrator to desist' and what they 'would have done differently before the stalking began or while it was in progress' were also posed.

Demographic Characteristics

Most victims were female (*n* = 13, 57%), with an average age of 50 years (*SD* = 7.67, range: 32-64) at the time of the survey. Victims had been seeing the clients who stalked them for a median of four weeks (range: 1-52) before the stalking behavior began. Victims were most often the sole focus of their stalker's harassment (70%), however, in some cases the perpetrator also harassed the victims' co-workers (17%), partner (13%), family (9%), friends (9%), and children (9%). Perpetrators were mostly male (65%) with an average age of 35 years (*SD* = 11.07, range: 17-50). Most perpetrators acted alone (*n* = 18, 78%). The majority of perpetrators were Canadian citizens (83%; 9% missing information), who spoke English as a first language (83%; 9% missing information) and were not a visible minority (83%; 9% missing information).

Data Analysis

Quantitative analyses were completed using SPSS v 21. Since the number of victims was limited and the literature does not provide a basis for hypothesis driven analyses, the analyses are primarily descriptive. Two cases synopses are provided to demonstrate the timeline, use and perceived efficacy of management strategies in context. This study focuses on the 23 counselors who were stalked. The larger sample of 346 counselors were the focus of Storey (2016) which examined the perceptions of stalking among counselors. No overlap exists in the data analysed.

Results

Characteristics of Stalking, Perpetrators and Victims

Nature of Stalking

Stalking persisted for 26 weeks on average (*SD* = 36.38, range: <1-112) (9% missing information). Stalking often occurred in multiple locations (*n* = 13, 57%) (4% missing information). 74% (*n* = 17) of stalking occurred at the office, 61% at the victim's home (*n* = 14), and 45% in public places (*n* = 10).

Victims reported whether there was evidence for the occurrence of the SAM Nature of stalking factors in the stalking they experienced (Table 1). Results showed that the more severe stalking behaviors, such as threats and violence, were rarer than the less severe stalking behaviors, such as communicating, approaching or having direct contact with the victim.

Perpetrator Risk Factors

Victims reported whether there was any evidence that the primary perpetrator possessed any of the Perpetrator risk factors in the SAM (Table 1). Results showed a high level of risk factor presence where, apart from substance abuse, in more than half of cases there was at least some evidence present for every risk factor.

Victims were asked to identify the perpetrator's motivation, mental health problems and level of distress. Motivations included romantic feelings (*n* = 9, 39%), an irrational belief (*n* = 9, 39%), a grudge or angry feelings (*n* = 7, 30%), and a desire for a non-romantic relationship (*n* = 7, 30%); in 6 (26%) cases victims were unsure about motivation. Perpetrators presented with a series of diagnosed mental health disorders. Axis I disorders included, mood (*n* = 9, 39%), anxiety (*n* = 7, 30%), dissociative (*n* = 4, 17%), substance-related (*n* = 3, 13%), psychotic (*n* = 2, 9%), and eating disorders (*n* = 1, 4%); four perpetrators (17%) had no Axis I diagnoses. Axis II

diagnoses included, borderline (*n* = 9, 39%), antisocial (*n* = 5, 22%), narcissistic (*n* = 3, 13%), and schizotypal personality disorders (*n* = 2, 9%); four perpetrators (17%) had no Axis II diagnosis. Since counselors could not diagnose clients it is possible that mental health problems were present but undiagnosed.

Perpetrator distress was identified in a variety of ways. Six (26%) perpetrators had made threats of self-harm or suicide. Most perpetrators (*n* = 18, 78%) had experienced a recent loss or stressor including the loss or potential loss of a family member (*n* = 4, 17%), child (*n* = 2, 9%), close friend (*n* = 1, 4%), intimate relationship (*n* = 11, 48%), employment (*n* = 4, 17%), or other loss or stressor (*n* = 4, 17%). Negative caregiver experiences during childhood were common (*n* = 15, 65%) and included, emotional abuse (*n* = 7, 30%), sexual abuse (*n* = 6, 26%), physical abuse (*n* = 5, 22%), loss of caregiver due to abandonment, death, or incarceration (*n* = 5, 22%), loss due to divorce (*n* = 1, 4%), and an emotionally absent caregiver (*n* = 3, 13%).

Victim Vulnerability Factors

Victims reported whether they had engaged in behaviors or experienced five SAM Victim vulnerability factors (Table 1). Results showed high rates of reported vulnerability, particularly related to engaging in inconsistent behavior and having inadequate access to resources. Only distress was endorsed by less than half of victims (44%) but is still notable given the high threshold required to meet this vulnerability factor which requires serious problems with negative emotions like anxiety or depression. More than half of victims (57%) reported an unsafe living situation (i.e., their home and/or workplace). When asked to describe their reasons for feeling unsafe six victims mentioned being alone (similarly two mentioned feeling safe because they were not alone), two victims mentioned not being able to escape (similarly one mentioned feeling safe because they could escape), two victims noted that they lived or worked in a bad

neighbourhood, two referenced a lack of awareness or concern by co-workers, and two mentioned a lack of office security.

Precipitating and Warning Signs of Stalking

Events reported to have precipitated stalking included the victim's refusal to enter into a romantic relationship with the perpetrator (*n* = 6, 26%), an unfavourable report or recommendation (*n* = 5, 22%), the termination of therapy (*n* = 4, 17%), the victim's refusal to enter into a non-romantic relationship with the perpetrator (*n* = 4, 17%), a significant stressor in the perpetrator's life (*n* = 4, 17%), the perpetrator's mental health issues (*n* = 4, 17%), or another form of conflict between the victim and perpetrator (*n* = 3, 13%). Some victims could not identify a precipitating event (*n* = 4, 17%) or were unsure (*n* = 3, 13%).

Warning signs displayed by the perpetrator that signaled the commencement of stalking included boundary crossing (*n* = 10, 43%), displays of inappropriate attachment (*n* = 8, 35%), misunderstanding of the therapeutic relationship (*n* = 6, 26%), arguments with the victim (*n* = 4, 17%), a history of harassment (*n* = 1, 4%), and refusal to complete an intake form (*n* = 1, 4%). Almost a third of victims saw no warning signs (*n* = 4, 17%) or were unsure (*n* = 3, 13%).

Risk Management

Management Strategies Employed

Table 2 displays the management strategies that victims recalled using. Ten victims made additional recommendations that they had not employed in their case. Four victims recommended seeking supervision, and individual victims suggested, trusting your gut, referring the client onwards, restorative justice (where no mental health issues exist), and working closely with police. Four victims noted that the appropriate strategies for a case depend on the situation since each case is unique.

Table 3 identifies whether and why victims chose to use management strategies commonly discussed in the research literature. Most victims employed some form of management and discussed the stalking with other MHPs rather than police. MHPs were contacted for support and advice as well as to pass on knowledge. Fear and the severity of stalking were strong motivators for contacting police, while the utilisation of other methods of managing the stalking was the most common reason given for not contacting police.

To investigate management strategies aimed at preventing future stalking, victims were asked to indicate whether they had made any of a series of changes to their clinical practice as a result of their experience. Half of victims (n = 12, 52%) reported that they now screen new clients, 10 (43%) increased office security, 10 (43%) included a more in-depth discussion of boundaries in their first session, seven (30%) increased their knowledge about stalking and violence, and three (13%) moved the location of their office; five victims (22%) made none of these changes. One victim described an additional change, which was acquiring personal security and a firearms license and training.

Perceived Efficacy of Management Strategies

Victims reported the perceived efficacy of the management strategies they employed (Table 2). For strategies identified as helpful, victims also indicated whether the strategy was the final strategy implemented in their case. Most notable, is that strategies reported as helpful by some victims were also reported as unhelpful by other victims, complicating the identification of exclusively helpful/unhelpful strategies.

Victims were asked to evaluate different sources of support available to them as well as indicate what support they wished had been available and what support they would recommend to other counselors. Responses (Table 4) indicate that co-workers, supervisors and family

provided the most support and that more support from employers was desired. Victims strongly recommended seeking support from co-workers and the police.

In describing why they believed the stalking behavior desisted, seven victims (30%) indicated that the perpetrator stopped on their own, whereas other victims referenced the management strategies employed (*n* = 8, 35%), a warning by someone other than the police (*n* = 6, 26%), the perpetrator selecting a new victim (*n* = 3, 13%), a peace bond (*n* = 3, 13%), a change in the perpetrator's personal life (*n* = 3, 13%), a police warning (*n* = 2, 9%), and a charge or conviction (*n* = 1, 4%). Three victims (13%) were unsure why the stalking ended.

When asked if there was anything that they would have done differently with respect to managing the stalking episode 10 (43%) victims said yes, eight (35%) said no and four (17%) were unsure (4% missing information). The changes that the 10 victims would have made included acting sooner (this was the only change mentioned by two victims), reaching out for help sooner, reaching out to more associates, listening only to experts, being clearer in written communication to the perpetrator, not confronting the perpetrator, not meeting the perpetrator face to face to request behavioral change, trusting their gut and not excusing or minimizing the perpetrator's behavior, requiring that an intake form be completed by all potential clients, educating themselves on issues related to stalking, not driving home when being followed but instead going to a public place and calling for help, not allowing themselves to be dismissed and pushing for policy changes or a policy to be written on this issue.

Case Synopses

A female counselor with over a decade of experience and training in violence risk assessment was pursued over two weeks in and around the office by a male client dealing with intimate relationship conflict. In noticing inappropriate behavior during session, that included

compliments unrelated to treatment, overly friendly behavior and attempts to gain more information about her, she first tired to speak to the client about it. She later refused a gift and had a male colleague act as a stopgap when she was followed in her car by the client. None of these strategies were helpful. The stalking ended after a male colleague took over the client's case, she reported that colleagues were supportive of her and her choices related to the stalking situation. The counselor reflected that despite her training she lacked the adequate knowledge regarding stalking and perpetrators of stalking to deal with the situation and that warning signs of stalking in her case included boundary crossing and displays of inappropriate attachment. She now screens all new clients for anger, attachment issues and therapeutic expectations and includes a more in-depth discussion of boundaries.

A second female counselor with over 10 years experience was being stalked at the time that she took the survey. Stalking had been ongoing for 12 weeks around the office and her home, and included repeated phone calls and emails, a threat to file a formal complaint and intimidating behavior (yelling and cursing). The perpetrator was a younger male former client who had been in counselling for mental health, social and life transition problems and showed evidence of all 10 SAM perpetrator risk factors. Stalking began several months after therapy terminated and was motivated by the client's dual and conflicting delusions that the victim is out to hurt him, and that she is the only one who can help him. The victim began by speaking with supportive and helpful friends and colleagues as well as asking building mates to be aware of unusual activity, these strategies were helpful. Next she notified the BCACC and they put her in touch with a colleague who was trained in stalking risk assessment and management. This strategy was identified as particularly helpful as it increased her understanding of her situation and the options available to her. She had no training in violence risk assessment. Next she changed her home

phone number and activated her home alarm. Although these increased feelings of safety it is unclear if they were helpful as they had only occurred recently. She also began to retain correspondence from the stalker, noting that she used to delete it as it was upsetting but now realises this was a mistake as it could provide evidence of the stalking behavior. If the stalking behaviour continues, her next strategy will be to call police.

Discussion

The nature of stalking experience by victims consisted primarily of less severe behaviors and low levels of threats and violence, which is in line with prior research. Perpetrator risk and victim vulnerability factors were prevalent, indicating a need for focused management in these areas. The perpetrator risk and victim vulnerabilities identified confirm previous research (e.g., high levels mental health problems and loss for perpetrators and the presence of minimisation for victims). Several perpetrator risk factors, known in the wider stalking research (as evidenced by their inclusion in the SAM), but new to the MHP literature were identified that can serve to identify the most appropriate targets for treatment among individuals who stalk their counselor (e.g., anger, obsessed, relationship problems). For victims, results also reveal the high prevalence of minimisation (i.e., inconsistent attitudes) as well as new and prevalent vulnerabilities possessed by MHPs such as inconsistent behaviour, inadequate access to resources and unsafe living situations. This study was the second to assess perceived efficacy among MHPs, and the use and perceived efficacy of risk management strategies revealed no single path to stalking cessation. However, for the first time we now understand why MHPs did or did not utilise management strategies and have knowledge of their experience-based risk management recommendations. Of note, is their satisfaction with and recommendation to seek help from co-workers and the police. Both strategies have been suggested as being unpopular among MHPs in prior research, in fact contacting police was also rare herein but a common recommendation.

This suggests, that with experience came a shift in perspective and that perhaps current victims of stalking would benefit from contact with prior victims. Overall, the findings related to risk and management suggest several areas that, if subject to targeted policy and education changes, could improve the management and prevention of stalking. Further, the results specifically indicate how MHPs want to be helped and their areas of need which if used to inform such policy could increase uptake and satisfaction.

The first area of focus that could improve management and prevention relates to the findings regarding perpetrators. Perpetrators presented with many risk factors and related motives for engaging in stalking. The high prevalence of some risk factors (e.g., mental health and relationship problems) is expected given that perpetrators were seeking treatment. Continued treatment will be required to reduce these risk factors for stalking (e.g., treat mental health disorders, to improve relationships). A victim should never provide treatment for a perpetrator, contact only serves to continue or escalate stalking (Storey & Hart, 2011). Thus, a pathway to treatment for perpetrators that limits risk to subsequent treatment providers needs to be created. Developing this pathway will require consideration of whether subsequent treatment providers can be notified about stalking risk. Information sharing is common practice in other professional contexts such as nursing and policing where centralised information systems exist such as hospital, medical and criminal records as well as internal databases held by such large organisations. For MHPs working with smaller organisations or in private practice such systems do not exist and requesting patient records requires patient consent. To protect MHPs, governing, regulatory or licensing bodies should develop and provide instructions to members on client referral after they have been subject to inappropriate or criminal behavior by a client. Two possible ways of instructing members are to clarify disclosure rules and/or identify appropriate

persons for referral. First, bodies could allow for some level of disclosure to future clinicians about the fact that the referring clinician was the target of inappropriate or criminal behaviour by the client. Under various Duty to warn or other Tarasoff (Tarasoff v. Regents of the University of California, 1976) type rules a legal pathway to disclosure without patient consent could be identified. A second avenue would be to identify professionals within the organisation to whom referrals could be made because they are trained to deal with clients with these types of issues and expect that referrals may be the result of prior stalking behaviour.

Motives for stalking were similar to identified perpetrator risk factors indicating that mitigating risk factors will also help to decrease risk by reducing the motivation to stalk. For example, over half of perpetrators were perceived to have a motive related to a desire for a relationship with the victim, either intimate or non-intimate. This motive is directly related to P6 (*Intimate relationship problems*) and P7 (*Non-intimate relationship problems*) but may also be related to P8 (*Distress*). Most perpetrators had experienced a recent loss or stressor, and most had negative caregiver experiences during childhood. This suggests that treatment related to healthy relationships and overcoming relationship loss and trauma may be key to preventing continued stalking. To identify the most appropriate targets for treatment a comprehensive violence risk assessment should be conducted using an empirically based tool.

A second area of focus for prevention is victims, who possessed high levels of vulnerability, particularly related to inconsistent behavior and inadequate access to resources. This is notable because the victims surveyed are educated and skilled MHPs with training in relevant areas such as mental health and relationship problems. This highlights the difficulty in managing stalking and the need to develop systems and awareness to support all victims.

The results indicate ways that vulnerabilities could be reduced and MHPs could be assisted in identifying and managing stalking. One way to mange vulnerability is by making victims aware of the factors that put them at risk, so that they can better monitor their own behavior and fulfill their needs. For example, making victims aware that holding inconsistent attitudes toward the perpetrator places them at risk could help victims to identify when they are endorsing such attitudes, monitor their subsequent behavior, and seek supervision to ensure that inconsistent attitudes do not impact their decision making. To further improve awareness, discussions about stalking and inappropriate client behavior could be modeled in training and encouraged as part of self-care. One way to provide this awareness would be through training prior to accreditation (e.g., graduate school). For example, in relation to this project the lead author (who had training in stalking and violence risk assessment as well as related practical experience with the police) provided training to several cohorts of BCACC students. Training consistent of one class (2-3 hours) and focused on areas of need such as the identification of stalking, how to get help and behaviours to avoid (e.g., continued contact, self-blame). This approach requires relatively limited investment by regulatory bodies but could potentially mean that stalking is identified and communicated to others quickly at which point management can be implemented. Case study 1 suggests that general threat/violence risk assessment training may not be sufficient and that stalking specific training is needed for MHPs to feel that they have adequate knowledge. Such training could also be augmented based on the new findings herein such as the warning signs that can precede the stalking of MHPs (e.g., inappropriate attachment).

Another more resource intensive type of assistance could also be provided once stalking has been identified. During the time of this study, and as exemplified in the second case synopsis, the BCACC identified a member, trained in stalking risk assessment and management,

who was available for consultation to counselors who were being stalked. Although the MHP in the second case reported herein was the first to participate in this new form of management and had done so only a week before taking the survey, she found the assistance to be extremely helpful and noted a marked improvement in her situation over the previous week. This form of assistance is more resource intensive (e.g., training, payment for service) but could provide help to members in a timelier fashion which could reduce the length of stalking and its consequences, limiting impacts like sick leave and burnout on staff. It would also mean that a low level of education, like that suggested above, could be provided to all other members since expertise was otherwise available within the organisation. Victims stated, and the results confirm, that there is no formula for managing stalking; cases require individualised management that considers risk. Thus, training one individual in stalking risk assessment would help to provide victims with access to resources that they identified as lacking and would provide appropriate consideration of risk in the management of stalking cases.

Where one-on-one assistance is not available other methods of sharing knowledge could be used, such as the publication of case studies, or webinars. We were made aware that after taking part in this survey some BCACC members began meeting to share experiences of stalking and to provide support to one another. The results indicated that victims preferred the support of their colleagues and wanted more employer assistance. Thus, providing these opportunities would be desirable and could increase help seeking. Further, as previously noted, victims tended to recommend that others use more management strategies than they themselves employed, thus providing this contact could be a means of sharing this valuable learned experience. Although such support could be invaluable, it is important to stress that cases are unique and that without larger scale studies to support the identification of effective management strategies, victims

should be encouraged not to make management decisions based entirely on the experience or suggestions of untrained individuals.

Another way to reduce vulnerability is to improve workplace safety. Over half of victims reported feeling unsafe at work or home, adding that being alone, unable to escape, limited security or lack of co-worker awareness made them feel unsafe. Working alone is problematic (Dubin & Ning, 2008), but could be ameliorated using buddy systems where MHPs have someone to check-in with. Governing bodies could also recommend that offices have a safety plan, including safe means of escape and communicating danger. For instance, code words or actions could be agreed upon within workplaces to communicate distress.

Limitations of the present study that should be considered in the interpretation of the findings include the small sample of victims and the decision to have victims to self-identify. The total sample of counselors surveyed was large however the response rate was low, and few respondents identified as victims of stalking. Although this might raise concerns about generalisability, the proportion of counselors stalked is in line with previous research (e.g., Kivisto et al., 2015; Romans et al., 1996), thus, there is no concern that the prevalence rate is anomalous. Though the sample size is limited, this study provides a more detailed investigation of issues related to risk and management than previous research. In future, offering an incentive or a clear path to impact through a regulatory body might encourage busy and often self-employed MHPs to participate. Further, Storey (2016) identified that within this group, counselors providing treatment for forensic, substance abuse, sexual abuse and issues with sexuality were most at risk. Thus, future work could focus on surveying such groups to increase sample size and target those most at risk. A second limitation is that in allowing counselors to self-identify as victims of stalking, at least two victims did not complete the full survey. Future

studies should consider asking a series of questions that identify stalking and then selecting victims based on defining criteria. Finally, a decision was made not to ask victims about the all the SAM Victim Vulnerability factors due to concerns about self-analysis and disclosure. Victims were however very forthcoming about vulnerability factors such as inappropriate behaviour and thus might have also endorsed other vulnerabilities as well. Although the ability to self-analyse remains unknown, it would be useful in future to examine all 10 SAM Victim Vulnerability factors. The present study also has several strengths. It is the first to examine empirically based risk factors and a violence risk assessment instrument in cases where MHPs were stalked by clients. The examination of victim vulnerability factors is particularly unique and revealed victim vulnerability factors that, if targeted, could help prevent and protect MHPs from continued stalking. In addition to examining the perceived efficacy of risk management strategies, for the first-time, results reveal precipitating factors, warning signs and reasons for management decisions that highlight ways in which victims can be assisted.

MHPs will continue to be at risk of stalking by their clients, owing to the nature of their profession and their distinctive role and relationship with clients. As such, unique management as identified herein such as seeking supervision and/or support from colleagues, referring the client onwards, client screening and setting and maintaining therapeutic boundaries are required. Due to their ongoing risk it is imperative that MHPs are provided with the education and tools necessary to identify warning signs, risk factors and effective methods of managing stalking. Changes should be made to education and policy to protect MHPs, the results of this study and existing methods for assessing and managing risk, such as violence risk assessment instruments, can provide guidance for that change.

References

Belfrage, H., Strand, S., Storey, J. E., Gibas, L. A., Kropp, P. R., & Hart, S. D., (2012). Assessment and management of risk for intimate partner violence by police officers using the Spousal Assault Risk Assessment Guide (SARA). *Law and Human Behavior*, *36*, 60-67

Canadian Centre for Justice Statistics. (2005). *Family violence in Canada: A statistical profile.* Ottawa, ON: Author.

Carr, M. L., Goranson, A. C., & Drummond, D. J. (2014). Stalking of the mental health professional: Reducing risk and managing stalking behavior by patients. *Journal of Threat Assessment and Management, 1*, 4-22.

Dubin, W. R., & Ning, A. (2008). Violence toward mental health professionals. In R. I. Simon, & K. Tardiff (Eds.). *Textbook of Violence Assessment and Management,* (pp. 461-482). American Psychiatric Publishing, Inc.

Foellmi, M. C., Rosenfeld, B., & Galietta, M. (2016). Assessing risk for recidivism in individuals convicted of stalking offenses: Predictive validity of the guidelines for stalking assessment and management. *Criminal Justice and Behavior*, *43*(5), 600-616.

Galeazzi, G.M. & DeFazio, L. (2006). A review on the stalking of mental health professionals by patients, prevention and management issues. *Primary Care and Community Psychiatry,11*, 57-66.

Galeazzi, G. M., Elkins, K., & Curci, P. (2005). Emergency psychiatry: The stalking of mental health professionals by patients. *Psychiatric Services, 56*, 137–138.

Gentile, S. R., Asamen, J. K., Harmell, P. H., & Weathers, R. (2002). The stalking of psychologists by their clients. *Professional Psychology: Research and Practice, 33*, 490-494.

Hart, S. D. (2001). Assessing and managing violence risk. In K. S. Douglas, C. D. Webster, S. D. Hart, D. Eaves, & J. R. P. Ogloff (Eds.), *HCR-20 violence risk management companion guide* (pp. 13-25). Mental Health Law & Policy Institute, Simon Fraser University.

International Legislation. (2014, January). https://www.stalkingriskprofile.com /what-is-stalking/stalking-legislation/international-legislation

Kropp, P. R., Hart, S. D., & Lyon, D. R. (2008). *Guidelines for stalking assessment and management (SAM)*. ProActive Resolutions Inc.

Kropp, P. R., Hart, S. D., Lyon, D. R., & Storey, J. E. (2011). The development and validation of the guidelines for stalking assessment and management. *Behavioral Sciences and the Law, 29,* 302-316.

Kivisto, A. J., Berman, A., Watson, M., Gruber, D., & Paul, H. (2015). North American psychologists' experiences of stalking, threatening, and harassing behavior: A survey of ABPP diplomates. *Professional Psychology: Research and Practice, 46,* 277-286.

Kivisto, A. J. & Paul, H. M. (2017). Stalking and online harassment of the private practitioner. In S. Walfish, J. E. Barnett, & J. Zimmerman Handbook (Eds.), H*andbook of private practice: Keys to success for mental health practitioners* (pp. 591-601). Oxford University Press.

Lion, J. R., & Herschler, J. A., (1998). The stalking of clinicians by their patients. In J. R. Meloy (Ed.), *The psychology of stalking: Clinical and forensic perspectives* (pp. 163-173). Academic Press.

MacKenzie, R. D., McEwan, T. E., Pathé, M., James, D. V., Ogloff, J. R. P., & Mullen, P. E. (2009). *Stalking risk profile: Guidelines for the assessment and management of stalkers.* Centre for Forensic Behavioural Science.

McIvor, R. J., & Petch, E. (2006). Stalking of mental health professionals: An underrecognised problem. *British Journal of Psychiatry, 188,* 403-404.

Meloy, J. R. (1997). The clinical risk management of stalking: "someone is watching over me. . . ." *American Journal of Psychotherapy, 51*, 174-184.

Mullen, P., Pathé, M., & Purcell, R. (2009). *Stalkers and their victims* (2nd ed.). Cambridge University Press.

Purcell, R., Powell, M. B., & Mullen, P. E. (2005). Clients who stalk psychologists: Prevalence, methods, and motives. *Professional Psychology: Research and Practice, 36,* 537-543.

Remark Web Survey 3 [Computer software]. (2003). Gravic.

Ring, M. (2018). Clients who stalking mental health providers. *The American Journal of Forensic Psychology, 36,* 31-48.

Romans, J. S. C., Hays, J. R., & White, T. K. (1996). Stalking and related behaviors experienced by counseling center staff members from current or former clients. *Professional Psychology: Research and Practice, 27,* 595-599.

Sandberg, D. A., McNiel, D. E., & Binder R. L. (2002). Stalking, threatening, and harassing behavior by psychiatric patients toward clinicians. *Journal of the American Academy of Psychiatry and the Law, 30,* 221-229.

Storey. J. E., & Hart, S. D. (2011). How do police respond to stalking? An examination of the risk management strategies and tactics used in a specialized anti-stalking law enforcement unit. *Journal of Police and Criminal Psychology, 26,* 128-142

Storey, J. E., Hart, S. D., Meloy, J. R., & Reavis, J. A. (2009). Psychopathy and stalking. *Law and Human Behavior, 33,* 237-246.

Storey, J. E. (2012). *Hurting the healers: Stalking in the mental health professions*. Simon Fraser University, Burnaby, British Columbia, Canada

Storey, J. E. (2016). Hurting the healers: Stalking and stalking-related behavior perpetrated against counselors. *Professional Psychology: Research and Practice, 47*(4), 261-270.

Tjaden, P. G. (2009). Stalking policies and research in the United States: A twenty year retrospective. *European Journal on Criminal Policy and Research, 15*, 261-278.

Whyte, S., Penny, C., Christopherson, S., Reiss D., & Petch, E. (2011). The stalking of psychiatrists. *International Journal of Forensic Mental Health, 10*, 254-260.

Table 1

Reported Presence Ratings for the SAM Risk Factors

SAM Domains	SAM Risk Factors	*N*	Present	Partial
Nature of Stalking Factors	N1. Communicates about victim	23	35%	22%
	N2. Communicates with victim	23	70%	13%
	N3. Approaches victim	22	43%	17%
	N4. Direct contact with victim	23	52%	9%
	N5. Intimidates victim	22	48%	0
	N6. Threatens victim	22	9%	13%
	N7. Violence toward victim	21	4%	13%
	N8. Stalking is persistent	22	43%	17%
	N9. Stalking is escalating	23	17%	22%
	N10. Stalking involves supervision violations	23	9%	4%
Perpetrator Risk Factors	P1. Angry	22	52%	13%
	P2. Obsessed	21	52%	17%
	P3. Irrational	22	48%	17%
	P4. Unrepentant	21	39%	17%
	P5. Antisocial lifestyle	22	35%	17%
	P6. Intimate relationship problems	22	61%	17%
	P7. Non-intimate relationship problems	22	52%	30%
	P8. Distressed	22	35%	22%
	P9. Substance use problems	22	13%	13%
	P10. Employment and financial problems	22	17%	39%
Victim Vulnerability Factors	V1. Inconsistent behavior toward perpetrator	22	96%	-
	V2. Inconsistent attitude toward perpetrator	23	52%	-
	V3. Inadequate access to resources	23	87%	-
	V4. Unsafe living situation	23	57%	-
	V8. Distress	23	44%	-

Note. SAM = *Guidelines for Stalking Assessment and Management* (Kropp et al., 2008). Present = evidence present, Partial = some evidence present.

Table 2

Frequency and Perceived Helpfulness of Risk Management Strategies

Management Strategies Implemented	Strategy Implemented (*N*)	Found Strategy Helpful (Final Strategy Employed) (*n*)
Office and home safety improvements	9	6 (0)
Peace bond	3	3 (1)
Terminated therapy	3	3 (1)
Clarified/set boundaries	7	2 (1)
Moved	2	2 (1)
Reported to police	3	2 (0)
Threatened to call police	1	1 (1)
Legal warning to cease and desist	1	1 (1)
Partner confronted perpetrator	1	1 (1)
Sought supervision	2	1 (0)
Made perpetrator aware that they were in a relationship	2	1 (0)
Called perpetrator's lawyer	1	1 (0)
Police protection	1	1 (0)
Sought counseling	1	1 (0)
Documented behavior	1	1 (0)
Warning by victim	2	0
Advised others of behavior	2	0
Ignored behavior	2	0
Partner threatened perpetrator	1	0
Warning by co-worker	1	0
Reasoned with the perpetrator	1	0
Limited sessions	1	0
Legal warning to cease and desist	1	0
Obtained no-go order from the court	1	0
Police warning	1	0

Note. $N = 15$. Although reported to police was noted three times, other strategies endorsed in this table require that a police report be made. This explains the discrepancy with Table 3 where eight victims indicated that they reported stalking to police.

Table 3

Frequency of Selected Management Strategies Employment and Reason(s) Endorsed for Action

Management Strategy	*n* (%)	Reason Endorsed for Action	*n* (%)
Reported to police	8 (35%)	Fear	8 (100%)
		Severity of stalking	6 (75%)
		Abundance of stalking behaviors	4 (50%)
		Escalating frequency or severity of stalking behaviors	3 (38%)
		Concern expressed by others	3 (38%)
Did not report to police	15 (65%)	Managed another way	12 (80%)
		Personal matter	4 (27%)
		Incident was not sufficiently important	4 (27%)
		Did not want to deal with police	3 (20%)
		Did not want the perpetrator to be arrested	3 (20%)
		Fear of perpetrator	2 (13%)
		Felt police could not help	2 (13%)
		Police would not help	1 (7%)
		Did not want anyone to find out	1 (7%)
		Fear of publicity	1 (7%)
Discussed with MHP	20 (87%)	Gain emotional support	13 (65%)
		Pass on knowledge	13 (65%)
		Obtain advice	12 (60%)
		Obtain help	11 (55%)
		Ensure the safety of other mental health professionals	7 (35%)
		Multi agency or team debrief	2 (10%)
		To document the stalking	1 (5%)
No management employed	8 (35%)	Unnecessary	3 (38%)
		Thought behavior would end without intervention	3 (38%)
		Unaware of strategies	2 (25%)
		Lacked confidence to employing strategies	1 (13%)
		Told not to by co-workers as incident was minor	1 (13%)

Note. Multiple reasons could be endorsed. Reporting to police was more frequently endorsed here than in Table 2. However, several strategies endorsed in Table 2 required that a police

report be made thus accounting for the discrepancy by indicating that police were contacted more than three times.

Table 4

Sources of Support that Victims Found Most Helpful, Wanted and Would Recommend to Other Counselors

	Source of Support	*n* (%)
Support that provided the most assistance deterring perpetrator's behaviour	Co-workers and supervisors	9 (39%)
	Family	5 (22%)
	Law enforcement	3 (13%)
	Other individuals	3 (13%)
	Friends	1 (4%)
	Victim services	1 (4%)
Support that provided the most assistance handling adverse effects of victimization	Co-workers and supervisors	8 (35%)
	Family	8 (35%)
	Friends	2 (9%)
	Other individuals	1 (4%)
Support that victims wished had been available to them	Employers	6 (26%)
	Co-workers	4 (17%)
	Resources on stalking	4 (17%)
	Law enforcement	1 (4%)
	Victim services	1 (4%)
	Regulatory body	1 (4%)
Support that victims recommend to other counselors	Co-workers	22 (96%)
	Police	20 (87%)
	Supervisor	18 (78%)
	Friends and family	10 (43%)
	Mental health professionals who are not co-workers	9 (39%)
	Victim services	7 (30%)
	Spiritual leaders	6 (26%)
	Lawyers	5 (22%)
	Doctors or nurses	2 (9%)
	Regulatory body	1 (4%)