Treatment of Stalkers – Part of Threat Management

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- Gail E. Robinson, University of Toronto: Stalking of Professionals: Findings and Preventive Strategies
- Werner Tschan, University of Zurich: Treatment of Stalkers – Part of Threat Management
- Totti Karpala, Helsinki Police Department: Stalking – Threat Management by Joint Task Forces
- Mindy B. Mechanic, California State University at Fullerton: Intimate Partner Violence and Stalking: Psychological Dynamics and Consequences
- Christine Kuehner, Central Institute of mental health, Mannheim: The Epidemiology of Stalking Victimization in Germany: Mental Health Aspects and Gender Differences
- Carleen Thompson, Griffith University: Stalking Violence: An Analysis of the Etiology and Escalation of Risk using an Integrated Theory of Stalking Violence.

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Abstract

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An offence focussed treatment for stalkers helps protect victims. The treatment approach is based on an understanding of stalking as a pathological behavior related to attachment problems. Stalking consists of a large variety of different behavioral patterns from simple phone calls and e-mails to dangerous assaults and use of weapons – however, one aspect is essential for treatment interventions: in any case stalking is always a relational offence.

Treatment of stalkers is part of threat management. Therefore, collaboration with other involved disciplines is essential. The presenter discusses experiences and limits of therapeutic interventions.

Introduction

I received a phone call from a lady who complained that there is a heap of helping facilities for stalking victims, but none for stalkers. The following case example illustrates her concerns:

> Her mother, age 64, a healthy woman working as a receptionist, has been stalking her former son-in-law for 6 years. Her sister get divorced from him a couple of years ago. For years the entire family has tried to stop her. She has been sending him e-mails, letters, phoning him, bringing him presents, loitering and hanging around in front of his flat, trying to talk with him whenever he is

there, sometimes waiting for hours. When family members confronted her with details of her stalking behavior, she continuous to deny everything, claiming that she has no contact with him, despite the photos the family took from her, and despite the large bulk of mail the family then presented to her. Under pressure from her family she went to see a psychologist, but when he asked her what he can do for her, she answered that she has no idea … She felt quite happy about her life, and denied any serious problems.

The lady asked me, whether there are any other options to help them sort out this problem?

This case example illustrates how easily psychiatrists, psychologists, and physicians can become involved in stalking cases. The high prevalence clearly indicates this – according to a meta-analysis including over 70'000 stalking cases one in four women and one in ten men will experience stalking at least once in their life (Voss 2004). Stalking includes a wide range of behaviors, ranging from courting behavior, love obsession to physical assaults and even murder cases. It is not easy to precisely describe stalking as a distinct phenomenon, because there are considerable overlaps with other forms of boundary violations and partnership violence, including dating violence.

Treatment approaches must also cover a wide range of behavior patterns, ranging from mild stalking to dramatic and dangerous cases which can only be handled in inpatient forensic settings. Both sexes can be stalkers. «Women are often found to engage in more low-level violence that characterizes most dating relationships that include physical violence than men. Women may also engage in more violent acts in marriages, although it is clear that the most violent forms of marital violence are much more often done by husbands to wives» (Frieze et al. 2002).

Stalking is always a relational offence, as stalking can not be committed alone. It goes far beyond the simple annoyance of persons or the damage of properties – stalking is a complex social interaction behavior with a considerable dynamic between offender and victim. Therefore there is a need for a specific anti-stalking law which considers the repetitive behavior and its impact on victims.

Pragmatic treatment approach

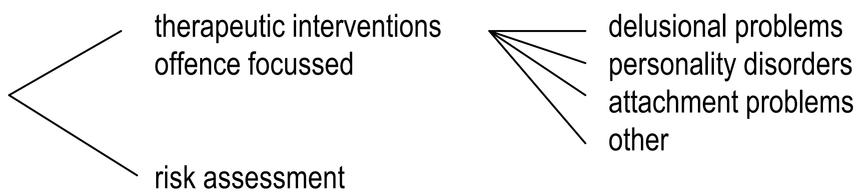
Typological approaches are not very usefull for treatment approaches in stalking cases. As a static concept they do not provide an understanding of the offender-victim dynamic over time. Often the determinants for escalation of threats and/or violent behavior are based much more on «dramatic moments» (Meloy 1996) than on personality traits and pathologies. A pragmatic approach in stalking cases is based firstly on the offence pattern.

When the aim of the treatment 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 unambiquous answers. This strategy is more defensive, where the stalker is often unaware about the intervention strategies; and it may therefore contribute in avoiding any further escalation, whereas any offensive strategy which is provided 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.

An expartner stalker persued his former wife over months, phoning her all the time, sending her e-mails, threatening her saying that she will see how powerful he is, in case she continues to refuse

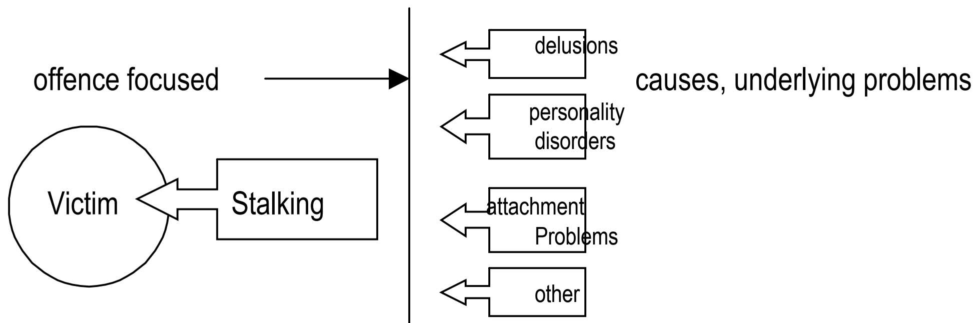
to see him, and alike. One day, he spotted her at a service station on the motorway, and then decided to follow her. When she saw him in her rear view mirror, she increased speed with the intention to escape him. However, he followed her and finally hit her car at a speed of over 140 km/h (~90 mph).

Lets assume this man is in your treatment and discloses his anger and his willingness to destroy his former wife's life. What would you do? This example illustrates, that 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 treatment process. In case of a increased risk to third parties there always lies a responsibility with the treating therapist to warn potential targets, according to the Tarasoff Doctrin. 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 confidentialty, 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.



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».

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 solve any underlying problems. In cases of escalation it is also of primary importance, to prevent any violent outburst, often only achievable in close co-operation with other disciplines, especially 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 confronted with delusional disorders (297.1 DSM-IV, F 22.0 ICD-10). The diagnostic criteria are the following (DSM-IV 2000):

A. Nonbizarre delusions of at least 1 months's duration.
B. Criterion A for Schizophrenia[1] has never been met.
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 the 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 affected person feel able to communicate their difficulties and perspectives. Cognitive

[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)

restructering (Wilken 1998) combined with 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 research.

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.

In accordance with 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).

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.

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). The case example with the stalker, who drove into his exwife's car, has experienced a very bad childhood – creating attachment problems, which must be addressed during treatment. However, attachment problems can never be an excuse for an unacceptable dissocial behavior.

D. 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 unexceptable 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 precodition for a succesfull 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 harassement; and early in the 1990s the implementation of Anti-Stalking Laws.

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 be 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 problem is sufficiently treated then the stalking behavior will disappear.

After a considerable paradigm shift from the understanding of interpersonal violence as a behavior problem not necessarily related to an underlying medical problem, to one based on social interaction misperceptions (e.g. de-valuating others; see for example De Zulueta 2006), treatment approaches based on the offence pattern became available.

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 intervention techniques which are provided simoultaneously – the cognitive behavioral interventions and the risk-assessment 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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