

Stalking of the Mental Health Professional: Reducing Risk and Managing Stalking Behavior by Patients

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Stalking is a prevalent issue that is often underreported and underdiscussed both in the general population and in clinical settings. Among mental health professionals, 6%–11% of providers will be stalked by a patient during their career. Stalking has a considerable negative impact on both the personal and professional lives of these individuals that is compounded by systemic and individual factors. Many health care organizations lack well-defined procedures on how to manage stalking, and mental health professionals have been found to have minimal training in how to address stalking behavior. Ethical guidelines across multiple health care disciplines emphasize avoiding harm and maintaining patient confidentiality. Although state licensing boards allow exceptions to confidentiality as mandated or permitted by law, these state laws may offer little protection to the mental health professional being stalked by his or her patient. Failing to address stalking behaviors could be detrimental to both current and future providers as well as preventing the stalker from receiving modification of problematic behavior. General models of stalking management have been offered in the past, but few address the specific challenges associated with the stalking of mental health professionals by their patients. The authors present 2 vignettes to demonstrate the common management challenges of these cases. The authors propose a dual pathway, 3-tiered model of stalking management that adopts a public health approach to guide interventions both on the individual provider and systemic level. Limitations and suggestions for future research are discussed.

Keywords: stalking, threat assessment and management, mental health professionals, case study, policy

Stalking is a prevalent issue that is often underreported and underdiscussed both in the general population and in clinical settings. It is

important to educate mental health professionals¹ and institutions in how to ethically and responsibly handle these situations to minimize

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¹ For the purposes of this article, the authors define mental health professionals as inclusive of psychiatrists, psychologists, psychiatric and mental health nurse practitioners, social workers, therapists, counselors, trainees in these fields, and any other clinician providing direct mental health services.

harm to the patient, mental health professional, and additional parties that may be involved. This education should include knowledge of the extent and types of stalking that one may encounter in the mental health setting; preventative measures; how stalking may escalate from, and initially appear as, common boundary and transference issues in therapy; and knowledge of violence risk assessment and management resources.

Our proposed management model was developed for implementation within the U.S. health care system. The implementation of this proposed model, however, could easily be adapted to a variety of international health care system structures. As there have been limited research studies of stalking behavior by patients in the United States, this article will borrow from international literature on stalking to enhance the understanding of stalking prevalence and impact.

Stalking Prevalence

Generally speaking, stalking involves repeated unwanted behaviors that reasonably cause the individual who is being stalked to experience fear of harm or death to self, family, or household. However, legal definitions of stalking vary by country and state.

It is estimated that in the general U.S. population, 16% of women and 5% of men are stalked (Black et al., 2011). Although it is unknown how many physicians are stalked in the United States, Canadian studies demonstrate that across medical specialties, psychiatry has one of the highest prevalence of stalking (Abrams & Robinson, 2011). In mental health settings in the United States, it is estimated that approximately 6% to 11% of therapists will be stalked by their patients at some point in their career (Roman, Hays, & White, 1996; Galeazzi, Elkins, & Curci, 2005, respectively), and at least one study of mental health professionals in Italy found that younger therapists may be more vulnerable (Galeazzi et al., 2005). Purcell and her colleagues found that in Australia, the prevalence of stalking of psychologists reached 19.5% (Purcell, Powell, & Mullen, 2005). Additionally, in a U.S. sample, 8% of therapists' family members and 10% of therapists' supervisees are stalked (Roman et al., 1996). Given this relatively large percentage, it is important

to educate mental health professionals and institutions in reducing risk and managing stalking behaviors by patients.

Although the modal stalker is typically described as a man in his 40s pursuing a prior sexual partner (Meloy et al., 2000), an Australian study found that 12% to 22% of stalkers are women (Purcell, Pathé, & Mullen, 2001). Approximately 40% of female stalkers, compared with 17% of male stalkers, stalk people with whom they had a previous professional relationship (Purcell et al., 2001). Most commonly, these professionals include psychiatrists, psychologists, and family physicians (Purcell et al., 2001) and involve some sort of perceived intimacy with the professional (Mullen, Pathé, & Purcell, 2009, pp. 191–192; Purcell et al., 2001).

Stalker Motivations

There are various, empirical ways that researchers have attempted to typify stalkers (e.g., Mohandie, Meloy, McGowan, & Williams, 2006; Mullen, Pathé, Purcell, & Stuart, 1999). For the purposes of this article, we have chosen to use a classification based on perceived motivation. Mullen and his colleagues termed five types of stalkers: (a) rejected, (b) intimacy-seeking, (c) incompetent, (d) resentful, and (e) predatory-type stalkers (Mullen et al., 1999).

Rejected stalkers seek reconciliation or some sort of revenge following a perceived rejection (Mullen et al., 1999). Mullen and his colleagues explain that in mental health settings, this might result from termination or ruptures to the therapeutic relationship. Rejected stalkers are likely to threaten their victims, and especially in previously intimate relationships, they often assault their victims. The rejected stalker may stop with threat of fines or legal actions. However, the extremely jealous and possibly delusional rejected stalker may not. Rejected stalkers whose behaviors are related to personality disorders may respond to mental health treatment (Mullen et al., 1999).

Intimacy-seeking stalkers seek or perceive special closeness with the victim (Mullen et al., 1999). They may misinterpret a mental health professional's empathy for intimacy (Mullen et al., 2009, pp.191–192, 1999; Purcell et al., 2001). Typically, intimacy-seeking stalkers do not tend to resort to assaults (Mullen et al.,

1999), although those with strong erotomanic delusions or infatuations may become violent (Mullen & Pathé, 1994). Involvement of law enforcement may be required to stop the stalking behavior although even legal intervention may not deter the intimacy-seeking stalker with strong erotomanic delusions (Mullen et al., 1999).

Incompetent stalkers often lack appropriate social skills and hope that their stalking behaviors will somehow lead to intimacy with the victim (Mullen et al., 1999). It is important to note that the term “incompetent” refers to the stalkers’ courting and social skills as opposed to their abilities to stalk; some incompetent stalkers are quite skilled at stalking. Incompetent stalkers do not tend to assault their victims, and they tend to respond well to limit-setting, involvement of law enforcement, and social skills training (Mullen et al., 1999; Zitek, 2002).

Resentful stalkers perceive a type of mistreatment and seek some sort of retribution or recompense (Mullen et al., 1999). As explained by Mullen and his colleagues, they often try to intimidate and create fear or distress in their victims through threats, though they infrequently resort to violence. In mental health settings, resentful stalkers may be experiencing paranoid ideation. They are often difficult to engage in mental health treatment, and sometimes involvement of law enforcement can worsen their behaviors (Mullen et al., 1999).

Predatory stalkers seek power and control over a victim (Mullen et al., 1999). Mullen and his colleagues explain that they are likely to engage in assault, often sexually, and there is often no warning to their attacks. They often have paraphilias and prior criminal records for crimes of a sexual nature (Mullen et al., 1999). Mental health professionals in forensic settings may more frequently encounter predatory stalkers than clinicians in other settings. These cases will likely require involvement of law enforcement, and once identified, predatory stalkers may possibly benefit from evidence-based biopsychosocial treatments for paraphilias and sexual offending (Mullen et al., 1999).

In terms of dangerousness across stalker motivations, Mullen and his colleagues explain that nonpsychotic stalkers are more likely to assault than psychotic stalkers. Previous history of substance abuse and criminal convictions also predict threats and risk of violence (Mullen et al.,

1999). Careful assessment of stalking motivations, mental health issues, and violence risk factors are crucial in assessing for risk and determining strategies to manage stalking behaviors by patients.

Negative Impact of Stalking on Mental Health Professionals

Stalking has a considerable negative impact on the individual who is stalked. It is estimated that 20% to 30% of individuals stalked in the United States seek counseling, and approximately one of every seven individuals ultimately changes his or her residence in an attempt to escape the stalker (Baum, Catalano, Rand, & Rose, 2009). Additionally, when compared with victims of other crimes, those who are stalked are much more likely to arm themselves with a weapon in response, with 3% of therapists reporting carrying a weapon to protect themselves against a former patient (Pope & Vasquez, 2011). In one Italian study, an estimated 8% of stalked mental health professionals thought about changing their profession, and approximately 5% ultimately left the field (Galeazzi et al., 2005). About a quarter of mental health professionals who are stalked reported lost time from work in order to evade the stalker and to obtain supportive services such as mental health care and consultation with attorneys (Galeazzi et al., 2005). Stalking has a chronic and pervasive effect on mental health professionals’ lives due to the intense fear that is often generated; the intimate nature of the crime; inadequate support from professional organizations, peers, and agencies; and the long duration of many stalking cases. Though many episodes of stalking last less than 2 weeks, beyond 2 weeks, the length of stalking episodes grows exponentially; overall, the average episode of stalking behavior lasts 2 years (Mullen et al., 2009).

Stalking also has social consequences that may further alienate mental health professionals from the support of friends and colleagues even beyond the length of the stalking episode. As suggested by research of individuals who have been stalked, mental health professionals who are stalked are likely to experience social isolation and being blamed by others close to them, which can lead to even more heightened levels of anxiety and distrust (e.g., Abrams & Robin-

son, 2008; Blaauw, Winkel, Arensman, Sheridan, & Freeve, 2002).

Many health care organizations lack well-defined procedures in how to manage stalking, and mental health professionals have been found to have minimal training in how to address stalking behavior (Dinkelmeyer & Johnson, 2002). Unlike state and federal statutes developed to address Tarasoff-type events, little exists to define the conditions sufficient to breach confidentiality when a patient stalks a mental health professional. It has been suggested that the lack of preparation and overall ambiguity in procedure results in poorly managed and underreported incidents of mental health professionals being stalked by their patients (McIvor & Petch, 2006). General ways to increase personal protection, home security, personal privacy, and so forth have been detailed elsewhere (National Center for Victims of Crime, 2009; StalkInc., 2011). The goals of this article are to expand on practical ways to address stalking of the mental health professional, which requires a conscientious response due to the laws and ethics surrounding the patient-clinician relationship. Further, this article discusses the need to establish policies in health care organizations addressing mental health professional stalking.

Ethical and Legal Issues

Ethical guidelines across multiple health care disciplines emphasize avoiding harm and maintaining patient confidentiality (e.g., American Medical Association, 2009; American Nursing Association, 2010; American Psychological Association, 2010). These guidelines unintentionally place a mental health professional stalked by a patient in a double bind, where acting out of concern for his or her own safety may result in both violations of privacy and negative consequences for the patient. In addition, stalking behaviors may begin as nonthreatening or benign and then develop into more problematic behaviors. The mental health professional may actually be aware of the behaviors but may misinterpret the intention behind these overtures. It can be difficult to differentiate between behaviors that are more common boundary violations, reflections of clinical pathology, and those that represent nascent stalking behaviors. Mental health professionals are trained to pro-

cess, ignore, or set limits with boundary violations rather than reacting with concerns about one's safety and considering the criminality of certain behaviors. Stalking management researchers recommend that mental health professionals examine all boundary violations from the perspective that they might progress into stalking and to seek legal and/or police assistance as early as possible, once violations are deemed threatening to the mental health professional (Lion & Herschler, 1998). The dual role of being clinical provider and being stalked, coupled with the covert nature of stalking behaviors and the emphasis on maintaining a therapeutic environment, has the unintended effect of limiting the capacity for a well-timed response and the degree of comfort in taking action when necessary.

State licensing boards typically allow exceptions to confidentiality as mandated or permitted by law; however, state laws and the Health Insurance Portability and Accountability Act (HIPAA) indicate that confidentiality may be breached under specific circumstances such as when a mental health professional believes a patient poses a serious and imminent threat to self or to others. In regards to stalking, the mental health professional outside of his or her professional role, would contact law enforcement if he or she were being stalked by a nonpatient. However, in the clinical setting, a mental health professional may not be protected by state laws or HIPAA to breach confidentiality when stalked by a patient. To further complicate matters, it is often difficult to distinguish between criminal and clinical behavior in psychiatric settings. For example, assault by psychiatric patients in hospital settings is more often than not treated as a clinical issue and not reported to law enforcement, such as in the case of frequent assaults on nurses (Henderson, 2003). Further, because of the variation in type and severity of stalking behaviors and because stalking is often defined by the stalked individual's emotional response, it is difficult to discern when these behaviors would warrant violation of confidentiality. Violation of confidentiality may lead to criminal and civil liabilities as well as possible suspension or revocation of license. There is an additional social liability. Too often, stalked mental health professionals have been met with criticism, skepticism, and alienation by fellow colleagues (Mullen et al., 2009,

p. 184). A vague definition, paired with high risk of negative outcomes, leads to underreporting and poor management of stalking behaviors.

Failing to address stalking behaviors could be detrimental to both current and future mental health professionals as well as preventing the stalker from receiving modification of problematic behaviors (Mullen et al., 2009, p. 196). About half of stalkers tend to reoffend (Rosenfeld, 2003), highlighting the importance of addressing behaviors early on to reduce the likelihood of future stalking and allow for appropriate management, monitoring, and intervention (Mullen et al., 2009, pp. 193–194, 196).

Strategies for Managing Stalking Behavior

Experts in the field of stalking (Mullen et al., 2009, pp. 194–196) have recommended a particular sequence of actions in cases where limit setting has failed and it becomes clear that it would be clinically inappropriate or unsafe for the targeted mental health professional to continue treatment. First, the mental health professional arranges a meeting between the patient exhibiting the stalking behavior, the clinician that the patient is being (thoughtfully) referred to, and/or the person that will administratively oversee the patient's case. This team then informs the patient that his or her intrusions were unwanted (Mullen et al., 2009, p. 195). If clinically appropriate, stating that the intrusions have caused concern and distress may serve as a corrective intervention in itself. However, it should be cautioned that depending on the motivation behind the stalking behaviors, expressing concern and distress may serve as positive reinforcement for the actions of the offender. In contrast, if the patient was not anticipating this response, he or she may experience a sense of shame or humiliation, which could increase the risk of violence (Meloy, 1997).

Second, the team should inform the patient that as a result of the unwanted intrusions, his or her care is to be transferred (Mullen et al., 2009, p. 195). It should be made clear to the patient that the targeted mental health professional will no longer be involved in his or her care and that there will be no further contact or communication with that mental health professional (Mullen et al., 2009, p. 195). It should also be stated that any continued attempts to contact or com-

municate with the mental health professional in any way may lead to their being criminally prosecuted (Mullen et al., 2009, p. 195). It may be clinically appropriate, for example, in the case where the targeted mental health professional had treated the patient for an extended period of time prior to the initiation of stalking behaviors to express regret that it ended in the way that it had (Mullen et al., 2009, p. 195). Expressing regret is not to be confused with apologizing. The team should be resolute in their decision, as well as clear and explicit in the outcome, and they should not allow for bargaining or debate from the patient. Although not discussed explicitly by Mullen and his colleagues (2009), when feasible, informing the patient ahead of time about the nature of the meeting may be clinically responsible and may reduce the possibility of rash, reactive responses during the meeting.

It has been suggested that if the patient continues to attempt communication with the mental health professional in any way, even if nonthreatening, it is important to deliver a consistent response (Mullen et al., 2009, p. 195). The targeted mental health professional should never respond to the ex-patient (Mullen et al., 2009; Sandberg, McNeil, & Binder, 2002). Instead, a third party such as a hospital administrator or clinic manager should send a clear and polite form letter that states that it is clinic or hospital policy that such communications are not to be reciprocated by the individual mental health professional (Mullen et al., 2009, p. 195). With each communication, the patient will receive the same response, which will hopefully reduce positive reinforcement of the behavior that may be gained from receiving different or novel responses. Depending on the seriousness and frequency of attempted communications, it may be advised to consider criminally prosecuting the patient (Meloy, 2002).

This response may be appropriate depending on the specifics of the case. In order to illustrate opportunities for prevention, risk assessment, and how interventions from both the mental health professional and institution may play out in real life, we will review two cases involving mental health professionals stalked by their patients. Details of the cases have been changed in order to protect the privacy of the individuals involved.

Vignettes

“Lisa’s” Story

“Tom” was a married man in his mid-50s who worked as a mixed media artist. He was receiving treatment for depression and chronic pain within an outpatient mental health clinic. Historically, Tom was unsuccessful in group therapy settings and therefore only was considered for individual therapy. Tom’s therapist, “Lisa,” was a well-respected, highly skilled clinician who had been employed in the outpatient mental health clinic for 20 years. Lisa’s therapeutic orientation was behavioral, and she was using cognitive-behavioral therapy to treat Tom.

During their first appointment, Tom requested a hug as well as insisting on calling Lisa a nickname. Lisa obliged these behaviors in this and subsequent appointments, seeking to establish a strong, warm therapeutic relationship with the patient. Although this was unusual behavior, it did not feel threatening or sexual. Tom responded rapidly to treatment, with depression symptoms and pain scale ratings reducing dramatically within the first several weeks. Concurrently, within the first few weeks of therapy, Tom began bringing items to session for Lisa to donate to other patients and clinic staff. He also began to bring in journal articles and art prints he thought Lisa may enjoy. Lisa asked Tom to stop bringing the items and attempted to return the journals and art prints, but he insisted she keep them. He continued to occasionally leave journals and art prints outside her office door after hours.

During the course of treatment, parts of sessions would occur in the clinic’s gardens. Walking around the gardens was something Lisa and other clinical staff had done with other patients in order to facilitate increased comfort, openness, and mindfulness. After about 6 months of treatment, Tom asked if it would be okay for him to take a few photos of the flowers by the garden when they went outside. Once out by the garden, Tom began taking pictures of Lisa. She asked that he stop, which he did. At a later session, Tom presented Lisa with a photo album of these pictures of flowers and of Lisa. It was at this time that Lisa became increasingly uncomfortable about Tom’s actions and questioned his motivations. Tom informed Lisa that

he was going to make an art project based on the photographs he had taken that day. She hoped that he was referring to the flowers and not the photos of her.

Several months later, Tom presented Lisa with a DVD of a clay animation movie, featuring a clay version of Lisa with another clay character who looked much like Tom out in the gardens. Tom stated the movie was technically for Lisa’s family because he knew that he was not allowed to give her any gifts. She waited until after session to watch the movie on her computer and immediately consulted with her male supervisor. As Tom’s clinical presentation continued to improve, Lisa and her supervisor determined it would be appropriate for her to approach termination. Soon after Lisa began to broach the topic of termination with Tom, he sent Lisa a poem he had written detailing how he would kill her family and move in with Lisa to be at her side “day and night” and to provide “comfort” and “solace” to her. He specified that all of these proposed events would take place 2 years post-termination of the therapeutic relationship so that it would not be overtly unethical per the American Psychological Association’s Ethics Code.

Lisa and her supervisor consulted with a multidisciplinary advisory board tasked with assessing and managing clinically based violence risk throughout the clinic. Lisa reported that during this consultation meeting, she was asked if she thought she could handle the patient’s behaviors therapeutically during this termination period. She expressed regret for responding that she could. As Tom had not reported imminent risk, Lisa was warned that contacting law enforcement or informing her husband or children would be an unwarranted breach of confidentiality. A meeting was arranged between Lisa’s supervisor and the patient to manage a transfer to a male provider.

When Tom arrived for his next appointment with Lisa, he was met by her supervisor alone. Tom was incredibly angered by this meeting and the boundaries that were set. Following this brief meeting with Lisa’s supervisor, Tom sent an extremely long and detailed handwritten letter to the clinic’s administration accusing Lisa and her supervisor of malfeasance. The letter also contained newspaper clippings about injustices in health care, photographs of Lisa, and photographs of Tom. Tom made clear his inten-

tion to send copies of this document out to a number of authorities and media in order to share his grievances if he were not permitted to see a female provider.

After review by the clinic's administration, Lisa was told to write a "point-by-point" response to the patient addressing the concerns stated in his letter. The clinic initially agreed with Lisa's supervisor and mandated that Tom no longer be allowed to receive his care at the clinic where Lisa worked and that he be assigned to a male provider. However, following continued pressure from Tom, they ultimately paid for him to receive care from a community-based female provider. In retrospect, review of Tom's medical records had no clear warning signs. There was no documented criminal history, and the only note suggestive of inappropriate boundaries was from over a decade ago. This note referenced Tom's self-report of a sexual relationship and obsessional thoughts about a female community college art professor.

Overall, Lisa reported that these incidents resulted in significant distress, including notable difficulties with her sleep, concentration, and her relationships with her coworkers and family. When Tom's focus on Lisa increased, and especially following his poem, Lisa found herself drained as she ruminated about these interactions. She described, "I [was] bleeding out at work," as she attempted to reach out to other colleagues for advice and support. She was warned by a coworker to stop discussing the case at work as it had become "juicy gossip." Lisa described a lack of emotional support or specific suggestions from coworkers beyond general safety tips (e.g., change routines, reduce online visibility). Lisa found herself feeling more alienated and alone in her experience. Though nothing was explicitly stated, Lisa perceived that her reputation as a professional had been tarnished. After 20 years of providing impeccable clinical service, her colleagues questioned how she handled the situation. She reported that despite having previously been quite social with her team, she continues to limit her interactions with her colleagues.

Lisa sought support in the community and found an ethics course taught by a local attorney to be quite empowering. The training provided her "real solutions" and preventative strategies, and both served to normalize and validate her experience as there were other clinicians in the

training who had similar experiences. As a direct result of this training, Lisa began to change her own practice, using both preventative measures and using different strategies to handle inappropriate behaviors by patients. Lisa finds that she is much more cautious and forthright with her boundaries. Emerging from her ethics training, she developed her own written informed consent, which provided substantial detail on inappropriate behaviors and their consequences. In addition, Lisa reported creating templates to track boundary violations throughout therapy. She also stated that she would no longer hug patients or conduct therapy outside of the office walls.

At this time, Lisa has not had additional contact with Tom. She remains quite fearful that Tom may return and hurt her or her family, though she thinks about it less each day. Similar to other individuals who have been stalked and in part because of the response from her peers, Lisa continues to question her own clinical decision making. Throughout her clinical work with Tom, Lisa never considered his actions to be stalking behavior, but saw them as a reflection of his characterological and social issues. In hindsight, she sees how her attempts to extinguish Tom's behaviors by not giving it attention and providing him with unconditional positive regard as a behaviorist and strengths-based therapist were unsuccessful. It was difficult for her to determine if or when to take action for fear of damaging the relationship and because the behaviors appeared nonthreatening at first and then insidiously progressed. Ultimately, when the behaviors were threatening enough and she consulted with her supervisor, neither could have predicted his reactions to their setting boundaries around his care.

"Mark's" Story

"Mark" was a psychiatrist at a large independent practice clinic where he saw "Dana" for therapy and medication management. Dana was a physical therapist in her mid-30s, married, with grade school-age children. Dana had been receiving treatment for chronic mood conditions and various Axis II, Cluster B traits. Shortly after initiating therapy, Dana began to leave Mark provocative voice messages about self-harm and danger that did not meet the criteria for hospitalization. As treatment pro-

gressed, Dana commented once about allegedly holding a psychiatrist at gun point when she lived in another state.

Mark stated the “tipping point” was about a year into treatment, when Dana had disclosed to him that she had looked up his home address and phone number. Later Mark’s wife found papers, left by Dana in their home mail slot, which appeared to be like entries in a diary. The writing described Dana’s attraction toward Mark and detailed fantasies about kidnapping him. In order to effectively manage Dana’s care, Mark sought a second opinion from another psychiatrist to provide consultation and help establish a new treatment agreement and plan. At their next meeting, Mark established various boundaries that Dana would need to maintain in order to stay in treatment with him. Over the following weeks, Dana very quickly violated each of these items, and Mark stated he needed to terminate treatment with her.

A few days later, Mark was at work after hours and heard a knock on the clinic’s door. When he went to the door he saw Dana, who was carrying a box of chocolates. Mark opened the door a crack to be able to hear Dana. He noticed something in Dana’s hand and realized that she was holding a gun. Mark shut the door, retreated to an interior room with no windows and immediately contacted hospital security. By the time that security arrived, Dana was gone. The box of chocolates was discovered sitting on the hood of Mark’s car.

It was suggested by hospital police that Mark not return home or to work. He contacted the local police for assistance, and because of the history of allegedly abducting a health care worker at gunpoint and fantasies about abducting Mark, the police arrested Dana. Dana was sent to jail, and Mark went on an extensive vacation out-of-state. Later, a friend who had been caring for Mark’s plants called to alert him that a dead cat with a bow on it had been left on his front porch. Upon calling the police, Mark discovered that Dana’s bail had been posted by her husband, and Mark had not been alerted. The District Attorney helped Mark go to court to get a stalking protective order. He also worked with his campus security to increase his security at home and safety at work. The security requested he park underneath hospital security cameras, and he had a security monitor installed in his office to watch people entering

and exiting the building. He expressed frustration at feeling the need to monitor everyone and everything around him. Concurrently, Mark would receive regular calls from local emergency departments, informing him that Dana had been admitted for homicidal ideation and that they were obligated to inform Mark, the named target. Mark additionally discovered that Dana had hired a private investigator to gather information on Mark, his wife, and their home security system.

Mark found the cumulative experience to be emotionally draining, and it began to affect his work. Mark often cancelled patients in preparation for scheduled court appointments, only to have the date moved at the last moment. This continued for 6 months and had a significant economic impact on Mark. Finally they had their court date, and Dana did not show. Dana was convicted of stalking, menacing, reckless endangerment, and unlawful use of a weapon, but pled down to 6 months probation. Dana also began to see another psychiatrist in the community. The day after the 6-month probation period had ended, Mark received a letter that had been sent through Dana’s psychiatrist, which is often referred to as stalking by-proxy. It was a letter of apology from Dana. This was a clear violation of the stalking protective order, and Mark wanted to have her arrested again. Despite his concerns, police were reluctant, fearing escalation.

The combination of the security measures, on-going contact by Dana through emergency departments, and the violation of the restraining order continued to wear on Mark. Additionally, Mark struggled to balance work with numerous appointments to obtain bids on surveillance systems, install bars on his house windows, and consult with police. He ended up taking a leave of absence for a few months. This was 9 years after the start of Dana’s stalking behavior. When Mark returned, he sensed that colleagues did not want to talk to him and that they questioned his reaction, believing that stalking “only lasted a little while and then went away.” He considered moving to another state or even changing careers, but he decided this might only “heighten the game” for Dana.

Eventually Mark started a new job at a different medical facility. He learned that unbeknownst to him, Dana had also transferred her care to this medical facility, prior to Mark ac-

cepting the position. Dana continued to stalk Mark by leaving him various objects at his home and work. Following the discovery of one of these objects, Mark called the police who collected evidence to dust for fingerprints. However, they failed to process it in a timely manner, and the evidence was too degraded to process.

It is unclear how, but also unbeknownst to Mark, Dana had her records expunged without the court informing Mark. Mark described this experience as “revictimizing” as there was nothing he could do, and the police were unable or unwilling to do anything at this time, with fear of “escalating” the situation. Around this same time, Mark received a call from his local psychiatry association and discovered that Dana had written to them expressing her concern for Mark and that Mark might have a stalker.

In addition to the tremendous amount of time, Mark experienced a significant impact on his own mental health and relationships. He pointed to the uncertainty of when the stalking would end and that his feeling in fear for his life for 15 years had led to significant hypervigilance. He resented how the stalking required him to “become invisible” and limited his career advancement and fulfillment in his work. In discussing frustration over the absence of recourse, Mark cathartically expressed a desire to sue Dana to compensate for damages.

Mark also experienced a loss of connection with his colleagues. He found the common reaction of intellectualizing (e.g., focusing on types of diagnosis, dissecting psychodynamics, not recognizing the level of danger) or “wide-eyed” titillation or fear as unhelpful. He found police to be the most helpful as they were action-oriented and focused on practical suggestions for safety. Despite not being notified when Dana’s stalking order was somehow terminated, Mark found his state laws to be supportive. He took a self-defense class, but did not find it helpful because he did not feel confident in defending himself against an armed assailant. Mark reported other “lessons” from his experiences, including wishing he had listened to the early advice of a colleague to terminate with Dana rather than acting out of his belief at the time that he would be “wimping out” if he did so. Mark regrets that the colleague did not talk through his thought process so that Mark could better understand what it was that led to the

recommendation to terminate. Mark also often finds himself an informal consultant to other colleagues who are also being stalked. He appreciates the opportunity to help others; however, he limits his consultation to pragmatic suggestions for safety and expressed a strong resistance to become too deeply involved in the “stalking world.” Mark voiced his observation that long-term stalkers tend to initiate contact when there are changes in a stalked individual’s life such as a death, marriage, or job change. Even years later, he continues to receive unwanted contact from Dana. He summarized his realization that, “You have to take your safety into your own hands. Organizations say they will protect you, but they will always protect the organization first.”

A Model for Reducing Risk and Managing Stalking Behavior by Patients

Using the lessons learned through the above vignettes as well as countless consultation cases and to assist in the response and on-going management of cases involving stalking of a mental health professional by a patient, we offer the following management model as an initial step in providing structured decision making. We propose this model, openly acknowledging the negative potential for developing reflexive or “cookie-cutter” thinking in regard to these admittedly complex and evolving scenarios. Despite these concerns, we believe the development of a preliminary model is the essential first step in what will hopefully prove to be an ongoing, collaborative refinement of the actions necessary to preserve mental health professionals’ safety, patient dignity, treatment fidelity, and confidentiality. The management model contains two main branches, individual and system foci, each with primary, secondary, and tertiary stages (see [Figure 1](#)).

Primary prevention strategies are interventions implemented pre-stalking incident that are globally applied. *Secondary prevention strategies* becomes necessary when two conditions are met: (a) a patient begins to test or violate boundaries and expected behaviors that had been agreed upon during informed consent; and (b) the mental health professional begins to have concern, discomfort, and/or fear about their patient’s behavior. *Tertiary prevention strategies* are to be used if the patient’s stalking

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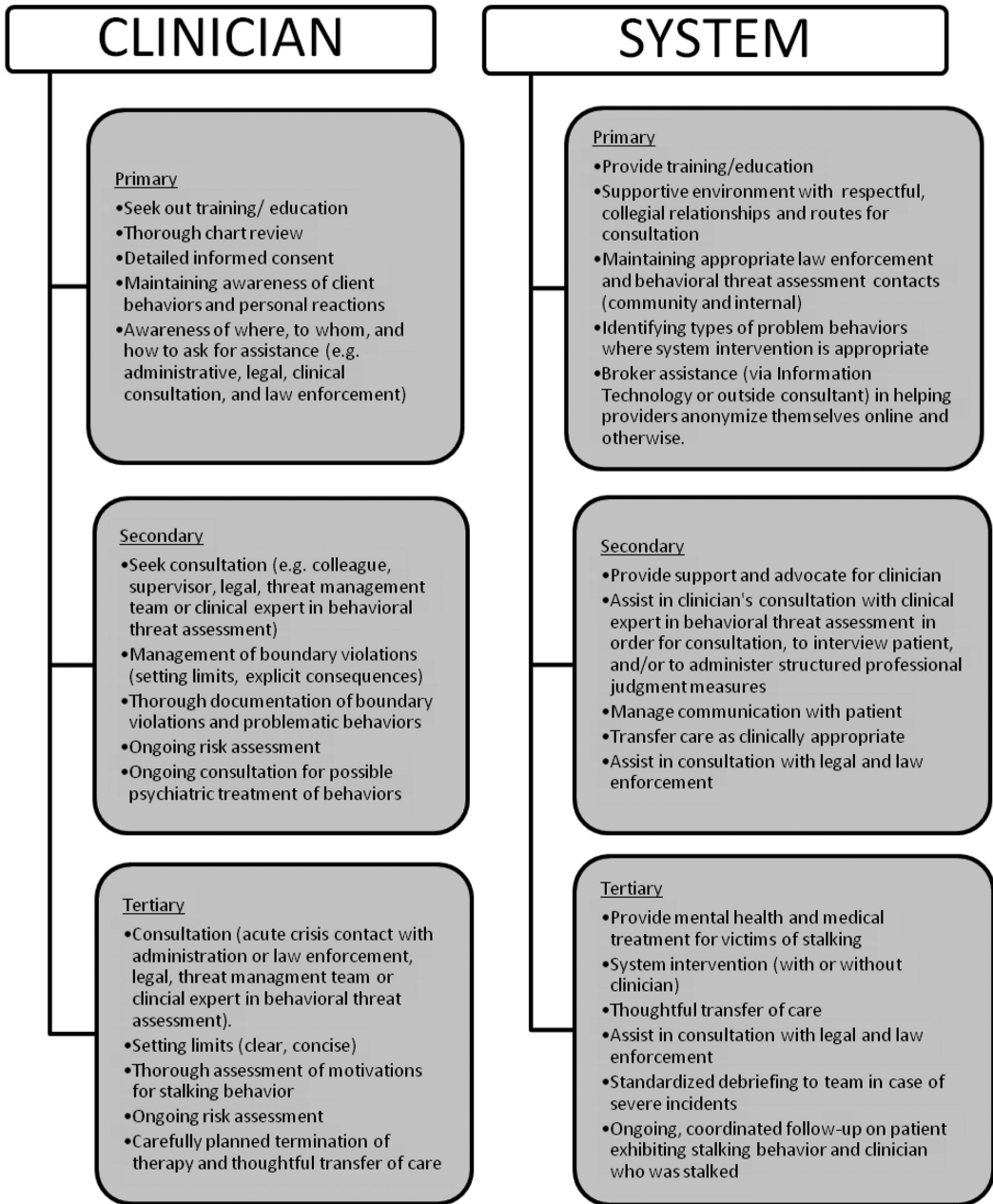


Figure 1. Stalking by Patients Management Model. This figure demonstrates the dual pathway, three-tiered management model for stalking by patients.

behaviors are sufficient enough to cause harm or threat of harm to the physical or emotional safety of the mental health professional or people and things close to the mental health professional. Different cases warrant a variety of

responses depending on the degree of severity and acuity, and as such, this model includes several different types of interventions within the primary, secondary, and tertiary intervention levels. Some cases may unfold rapidly and

require utilizing more tertiary interventions immediately, whereas others may require ongoing, less frequent adjustments. These interventions are also not all-inclusive, and it is important to use clinical judgment and consultation in selecting the most appropriate response given the specific situation.

Individual Interventions

Primary Intervention Strategies for the mental health professional will initially focus on education. Mental health professionals should seek education and training so that they will be able to identify stalking behaviors, understand general violence risk factors, and know appropriate and available actions. Mental health professionals could attend rotating in-service education, annual trainings, and new employee didactics that address issues of clinician safety. Mental health professionals should also seek curriculum that is grounded in current research in stalking, patient confidentiality, and violence prevention. With every patient, mental health professionals should proffer a detailed informed consent that both addresses more traditional concerns such as threat to self and third parties but also explicitly specifies inappropriate behaviors and consequences (see the [Appendix](#)). Many health care organizations have already successfully implemented similar policies. It is recommended that mental health professionals conduct a thorough chart review and consistently engage in interdisciplinary communication that may reveal “blind-spots” that could negatively impact both patient safety and the safety of the mental health professional.

Throughout treatment, mental health professionals should maintain a level of conscientiousness of possibly inappropriate patient behaviors (e.g., gifts, breaches of privacy, and boundary violations, which attempt to expand the relationship outside of the therapeutic frame), and they should not dismiss the value of their own personal reactions to such patient behaviors. It is understood that cultural values may play a role in some gift giving and boundary violations. Clinical judgment and cultural consultation will be helpful to differentiate between cultural issues and more problematic behaviors. Careful consultation and examination of the historical, contextual, cultural, and clinical factors provide the best method of determin-

ing when behaviors have crossed the subjective line of appropriateness. When behaviors are suspected to have crossed the line, mental health professionals should have ready awareness of where, with whom, and how to request assistance. For mental health professionals in hospital, forensic, and university settings, there may already be a structured model for consultation and collaboration with legal, law enforcement, and other social service providers. For those mental health professionals in independent practice, it is ever important to maintain collegial relationships for consultation and to actively develop working relationships with legal, law enforcement, and other social service providers in the community.

Secondary Prevention Strategies for the mental health professional will include initiating further consultation with colleagues, supervisors, the institutional threat management team, legal counsel, and law enforcement. Consultation should be multifactorial, consisting of informal social support from colleagues and more directive, supportive responses by the supervisor. The institutional threat assessment team, if in existence, brings structured risk assessment and management expertise to the case, and law enforcement will provide additional expertise in management as well as provide the mechanism for enforcement should laws be violated and containment be warranted.

Secondary prevention will also include setting limits and addressing boundary violations, as well as documenting steps taken in the medical record. At the point in which the therapeutic relationship has been ruptured to the degree that it cannot be salvaged (e.g., a pattern of persistent boundary violations culminating in a threat), it becomes increasingly important to thoroughly document behaviors tangential to the patient’s therapeutic progress. This includes all gifts, breaches of privacy, and boundary violations that attempt to expand the relationship outside of the therapeutic frame. Rather than recommending specific documentation in or outside of the medical record, each mental health professional should determine the preferred method for documenting unwanted approach behaviors before and after terminating with a patient in collaboration with his or her own supervisors and legal counsel.

It is additionally important to evaluate any possible acute mental health interventions for

the stalker that may ameliorate problematic behavior. Brief hospitalization stays or changes in medication should be considered and may aid in reducing unwanted patient behavior. It is recommended that any clinical decision at this level of intervention be pursued within multidisciplinary consultation and be evaluated for its potential to compromise the mental health professional's safety. The multidisciplinary consultation and team approach is especially important as it is often difficult to monitor and determine if a patient's behaviors represent more clinical issues that can be managed through mental health treatments or if they are nascent stalking behaviors that carry risk to the mental health professional.

Tertiary Intervention Strategies for the mental health professional will consist of initiating an acute crisis contact with administration or law enforcement. When a threat is made or when a patient's behavior places a mental health professional in the position of feeling threatened, the therapeutic relationship is devoid of trust and safety and in sum, destroyed. At this level of threatening or fear-provoking behavior, limits need to be set, and these limits must be clear, direct, and absent of ambiguity. It would be clinically inappropriate and unethical for the mental health professional to continue to see the patient.

At this point, for mental health professionals operating in independent practice, it becomes particularly difficult to navigate the ethical concerns of trying to not abandon care for a patient with the reality that there is no longer a safe, therapeutic bond with the patient. Assistance from legal counsel and law enforcement may be necessary to establish the limits around communication between the mental health professional and patient in the future and how to best transition the patient safely to another clinician if appropriate. Referral to a new mental health professional should be made thoughtfully, considering issues such as clinical experience, gender, and level of risk. Referral to a mental health professional out-of-system may be an appropriate option in some cases but should involve thorough, ethical transmission of information regarding risk factors as well as the ability to maintain on-going follow-up.

In planning for when and how to transfer patient communication from the mental health professional to the system or to another clini-

cian, it is especially important to consider the specific motivations behind the patient's behaviors and risk factors. Although the suggestions of Mullen and his colleagues (2009, p. 195) to relinquish management of the patient's care to the supervisor/administration and severing communication between the mental health professional and the stalking patient may prove clinically appropriate and beneficial, the way it is handled needs to be adapted for each patient. Again, it is important to avoid reflexive or "cookie-cutter" thinking.

Some responses that may be helpful for one type of stalker may prove counterproductive for other types of stalkers. For example, the level of risk may increase in the case of a resentful stalker patient who is continuously met with road blocks in trying to feel heard and understood or to get his or her needs met and who may develop "last resort" thinking. In the case of the intimacy seeker or erotomanic stalker, receiving repeated letters from a supervisor may be interpreted as interference with "true love," unintentionally reinforcing the stalker's delusion. With an erotomanic stalker, the intervention strategy should rather consider the effectiveness of a face-to-face meeting with the supervisor and maintaining an enhanced readiness to activate law enforcement's involvement as part of the overall prevention strategy. It is also highly important to evaluate the potential for an intervention strategy to represent a humiliation to the stalker—thus amplifying the degree of risk rather than promoting risk mitigation (Meloy, 1997). At this level of intervention, determining the details of how to intervene is best assessed in consultation with clinical experts in behavioral threat assessment.

After the intervention, thorough documentation of any attempts for future communication should be kept. A report of incident(s) should be communicated to supervisors, institutional threat assessment team, administration, and/or law enforcement, depending on the decided pathway of incident reporting.

Systemic Interventions

Primary Prevention Strategies for the system start with providing all mental health professionals on-going training and education in clinician safety, including identifying stalking behaviors, ways that the system will support the

mental health professional with a range of problematic patient behavior, appropriate methods for a mental health professional to seek assistance when they believe they are being stalked, and practical solutions to increase safety for the mental health professional. The general education of mental health professionals will aid in preventing the social isolation many stalked mental health professionals experience from colleagues by improving their understanding of the insidious emergence of stalking behavior. Using a top-down approach, clinic administration must create and maintain a culture of support. Supervisors and administration should be both task- and person-oriented. They should be aware and sensitive to the unique issues and needs involved with stalking at a patient, mental health professional, and systems level. They must create ample opportunities for consultation with mental health professionals, and administration should respect and be responsive to the mental health professional's clinical judgment and experiences. Supervisors and administrators must maintain a level of communication and trust with mental health professionals so they may work closely and intervene from a systems level when specific problematic patient behaviors emerge or high risk for stalking behavior is identified.

Health care organizations are also responsible for maintaining appropriate legal and law enforcement contacts in order to facilitate this consultation as appropriate. Within this network, it is recommended that the system obtain the participation of a local clinical expert in behavioral threat assessment who has experience and training in the use of structured professional judgment measures, such as the Historical, Clinical, Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) or stalking-specific violence risk assessment tools such as the guidelines for Stalking Assessment and Management (SAM; Kropp, Hart, Lyon, & Storey, 2011), and the Stalking Risk Profile (SRP; MacKenzie et al., 2009). This would ensure valuable expertise in the immediate intervention and on-going management of stalking cases. If a local expert cannot be identified, contacting a local professional organization or local chapter of a national organization such as the Association of Threat Assessment Professionals is recommended. It may also be prudent for health care organizations to consider providing assis-

tance through their own Information Technology departments or outside consultants in order to help mental health professionals reduce or alter their public and online visibility as deemed appropriate or necessary for their safety within and outside the professional setting.

Secondary Prevention Strategies for a system will include calling on their established networks of other clinicians, administration, local clinical experts, legal practitioners, and law enforcement to consult or intervene as appropriate. These consultations can be focused on both the health and safety of the patient and the mental health professional. In order to support the mental health professional and provide a unified front, administration can have direct conversations with the patient about appropriate behaviors, clinic policies, boundaries, and ramifications of crossing the boundaries with or without the mental health professional's presence. The system should assist mental health professionals in identifying when it is appropriate to transfer care and may facilitate the transfer process. The system can also assist with modifications of treatment plans and treatment agreements if it is appropriate for the mental health professional to continue seeing the patient.

Some mental health professionals will have strong reactions to boundary violations that, to the trained violence risk professional, may not pose real threat or risk of violence. For example, we have seen mental health professionals who interpret a patient's use of strong language and references to violent thoughts or fantasies as threats and who will transfer the patient. Alternatively, we have seen mental health professionals who deny the reality of behavior, which experts who have evaluated the case found to be of significant concern. This is often the mental health professional whose professional self-concept is one of "I take all the tough cases that no one else can handle. I can handle this one too." These reactions are not necessarily opposing ends of the same continuum. We have seen a tendency for some mental health professionals to move quickly from denial to overreaction or the reverse. Of course, the concerns of a mental health professional who reports feeling fear of a patient must always be taken seriously. However, there can be significant consequences for the patient if he or she is incorrectly labeled as

a true threat. This is why systems must make available expert consultants and support for the mental health professional. When doing so, careful consideration must be paid to the potential for causing further distress. Consultants must be thoughtful, informative, and supportive of the mental health professional who may be faced with serious boundary violations or frank threatening behavior while also helping the system to avoid Type I or Type II assessment errors.

The use of structured professional judgment measures such as the HCR-20 (Webster et al., 1997), SAM (Kropp et al., 2011), or SRP (MacKenzie et al., 2009) and interviews of the patient by a clinical expert in behavioral threat assessment are an opportunity to gather rich information and gain an understanding of his or her perspective, motivations, emotional experience, risk factors, protective factors, wants, and needs.

Tertiary Prevention Strategies for the system will include intervening on behalf of the mental health professional, with or without the mental health professional's presence. They must draw boundaries around the patient's care and interactions with clinicians in the clinic. The patient's care should be transferred thoughtfully within the clinic or to an external clinician. Again, as previously mentioned with regards to the mental health professional's interventions, the motivation for the stalking behaviors must be carefully considered in consultation with experts in behavioral threat assessment in order to inform the intervention.

The health care organization should also link the mental health professional with legal practitioners and law enforcement to keep the mental health professional safe from malpractice lawsuits and personal or professional injury or harm. In order to maintain a culture of open dialogue, safety, and a supportive team, administrators should provide a standardized debriefing to the mental health professional's clinical team in the case of severe incidents. In order to respect the mental health professional's and patient's privacy, while stressing the importance of the mental health professional's safety and the system's support of the mental health professional, they should limit these debriefings to (a) a general indication of what occurred, (b) how the clinic has responded to the situation, (c) what risks may persist for the individual as well

as other clinical staff, and (d) what is needed from the clinical staff.

The health care organization should also assist the mental health professional in locating resources for personal support in coping with being stalked. The health care organization may consider providing the mental health professional with mental health and medical care or leave of absence to reduce levels of stress and risk of harm related to the stalking incidents.

Conclusion

The central dilemma faced when a mental health professional is stalked by a patient is one of conflicting duties driven by an inherently difficult behavioral challenge. The dual role of clinical provider and being stalked, coupled with the surreptitiousness of stalking behaviors and the emphasis on preserving the therapeutic environment, limit the capacity for a well-timed response and the degree of comfort in taking action when necessary. As it was in both the case of Lisa and Mark, providers were both torn between balancing their clinical obligations and personal safety. The already challenging situation was further complicated as both mental health professionals felt significantly isolated by the overall experience due to the lack of available consults and support. This is the essential, unique challenge that was the impetus for the development of a structured decision-making tool. The management model presented attempts to harness the established literature on stalking and offer a dual pathway, three-tiered decision-tree, operating on both an individual and systems level. The model is not offered as the penultimate solution, but as an essential first step. As is the case with most initial models, ours is not without weaknesses. First, we once more emphasize that we do not intend for this to lead to reflexive or "cookie-cutter" thinking. We hope that the importance of consultation and supervision have shown through our model, as they will be key in assessing complex and evolving scenarios between mental health professionals and their patients.

Second, there is much more to be learned about the various motivations behind stalking behaviors and which interventions may lead to more successful results depending on the motivations. Maintaining awareness of how interventions may elicit different responses from

stalkers with varying motivations will be central to mitigating risk. In each case, careful consideration should be given to how the intervention will be interpreted. The willingness to explore all options (letters, face-to-face meetings, and utilization of law enforcement) should be carefully evaluated for how they may be received by the stalker. By considering the perspective of the stalker, we reduce the possibility of an innocuous-seeming intervention being unintentionally seen as a humiliation. It is highly important to evaluate the potential for an intervention strategy to represent a humiliation or lead to “last resort” thinking—thus amplifying the degree of risk rather than promoting risk mitigation. With appropriate expert consultation, mental health professionals and systems will be able to form nuanced plans specific to each case.

Third, in discussing system-level responses, we recognize that not all mental health professionals may operate in a system with all of the resources discussed. There are many mental health professionals in independent practice or agencies with limited administrative support and with minimal available consultative resources assumed by this model. Consequently, a much needed area for development is the creation of modifications to this model that explicitly address the unique demands posed by independent practice. Suggestions for the model include the determination of appropriate contacts with local police (often within the domestic violence units), consultation with an attorney versed in both criminal and privacy law, and the establishment and maintenance of consultative support of other clinicians and local threat assessment experts. As one of the hazards inherent in the use of any decision-tree type model, it cannot adequately address the diverse demands posed by unique cases and complex institutions. As a result, intentional effort was paid to maximizing flexibility within the model. One such example can be found in documenting unwanted approach behavior. Within a Veterans Affairs Medical Center, such documentation could be immediately provided to the Veterans Affairs Police. This option would not be immediately available to mental health professionals in the community, who would need to consider issues of confidentiality prior to contacting an outside police agency. Rather than attempt a one-size-fits-all solution, we recognize the need

for collaborative decision making that takes into account these types of constraints.

Future research could benefit from a longitudinal analysis of the dual pathway, three-tiered management strategy, assessing for outcomes on the mental health professional, patient, and system. Particular areas of interest regarding the patient include: the number and severity of safety incidents involving the patient, salient mental health clinical outcomes, and quality-of-life factors. Particular areas of interest regarding the mental health professional include: the impact on quality of life, the number and severity of safety incidents affecting the mental health professional, the perceived level of social support, and mental health clinical outcomes. In regards to the system, it would be important to assess number and severity of safety incidents, staff morale, staff retention rates, and staff performance ratings.

Overall, this is an important and ethically complex topic that must continue to be examined in order to generate the most effective strategies to manage stalking behaviors by patients. Using the lessons learned from “Lisa” and “Mark” and research from experts in the field, we have created a model to help ground and empower mental health professionals and systems to respond when faced with the complicated and often confusing situation when a mental health professional is stalked by a patient. We welcome changes and improvements to the model as we all work together to help build collaboration and companionship with our colleagues who may find themselves traveling this difficult path.

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Appendix

Sample Informed Consent Form

Clinician's Name
 Position Title
 License #12345678

Some Things You Should Know About Counseling (AKA Informed Consent)

Before you start counseling, there are some things you ought to know. Legally, this information is called informed consent. Informed consent will help you understand better what to expect from your work in counseling here, and it will explain some limitations to what we will be doing.

Side Effects and Other Potential Unpleasantness

You should know that counseling is not always easy. You may find yourself discussing very personal information, which may be difficult and even could be embarrassing. As you learn more about yourself, you may find you have increased conflict with friends, family, or coworkers. It is possible you may become more anxious and depressed for a time. Counseling is intended to alleviate problems, but sometimes,

and especially at first, you may feel them even more acutely than in the past. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and fewer feelings of distress. Therapy also calls for a very active effort on your part. In order for the therapy to be most successful, it is recommended you work on things we talk about both during our sessions and at home. You will always be free to move at your own pace, however. Although I will use therapies that have been shown to produce reliable change, no guarantees can be made about the results. If I believe your problems require knowledge I do not have, I may refer you for a consultation with someone with specific training. I will discuss any referral with you before I act. At the beginning of treatment, we will create a treatment plan for you together. That is, we will look at what you would like to change, what we will do to change it, how to know if

(Appendix continues)

you are succeeding, and how long it will take. Every now and again we will review the plan to see if it needs to be updated.

Therapy involves a large commitment of time and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

Training and Approach to Therapy

I have a [EDUCATIONAL DEGREE] earned in [YEAR] at the [INSTITUTION]. I am a [SPECIALTY] in [STATE/COUNTRY]. My areas of special training and expertise include [DETAILS]. My approach to therapy is [DETAILS]. I use a variety of techniques in therapy, including [DETAILS].

Therapeutic Relationship

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. Because a person typically shares personal and private information with their therapist, a close and caring bond may develop. However, a therapeutic relationship differs greatly from a friendship. In a friendship, caring and support goes both ways. Each person relies upon the other. However, for therapy to work, it is important to note that the relationship is here for you alone to do the work you need to do. Because of that, I will maintain professional boundaries with you. This means I will not meet you outside the office for social activities, accept gifts, or become intimately involved with you. Similarly, I will not contact you or accept contact via social networking websites. Because you have a right to confidentiality, should we happen to see each other by chance in the community, I will not greet you. This does not mean I am being rude. Rather, it means I am protecting your privacy so you don't have to explain how you know me to anybody else and I do not

have to reveal to anyone I might be with that you are my client. Should you wish to greet me, in such a circumstance, I will be happy to greet you in return.

Ending Therapy

You normally will be the one who decides therapy will end, with three exceptions. First, if we have agreed to a specific, time-limited course of therapy, we will finish at the end of that time frame. Second, if I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are not appropriate, I will inform you of this fact and refer you to another therapist who may better meet your needs. Finally, if you verbally or physically threaten, harm, or harass me or my family, I reserve the right to terminate your treatment immediately. If I terminate your therapy, I will offer you referrals to other sources of care.

Meetings

I will usually schedule one [TIME DURATION OF SESSION] session each week at a time we agree on. Once we have scheduled an appointment, you will be expected to attend unless you let me know in advance (or unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, I will try to find another time to reschedule the appointment. I value the work we will be doing together, so it is important for us both to arrive on time for our meetings. I realize sometimes unforeseen circumstances arise, but I will not start a session if you arrive more than 20 minutes after the scheduled start time because there won't be enough time left in that hour to do the work of therapy. I usually have people scheduled after you so I can't start late and run overtime. If I am not able to attend a session, I will make every effort to contact you to cancel the session at the earliest possible opportunity.

(Appendix continues)

When you come to a session, please be sure to bring any homework you have from the previous session—whether or not you have completed it. Although I encourage you to make every effort to complete homework, it is better to bring what you have rather than nothing at all. Also know that this therapy office is a weapons-free zone. To ensure everyone's safety, please leave firearms, knives, pepper spray, tasers, and large rocks at home. If you use a cane but have a tendency to waive it around expressively, I may ask you to place it on the floor after you are comfortably seated.

Contacting Me

I am usually not immediately available by telephone because I do not answer the phone when I am with a patient. My telephone is answered by voice mail, which I monitor frequently. I make every effort to return your call within 24 hours of the time you called, with the exception of weekends and holidays. Please note I do not return calls after [TIME]. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. If you are difficult to reach, please let me know some good times to reach you. In case of an emergency, please call 9-1-1 or [APPROPRIATE CONTACT NUMBERS]. You may also go to the nearest emergency room.

The Internet is not a totally secure medium for purposes of transmitting counselor–client or other privileged information. Please know that e-mail communication can be relatively easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of that communication. Because of this, e-mails containing information about people who may be patients will not be responded to so as to protect their privacy and confidentiality.

Professional Records

The laws governing psychologists require us to keep treatment records. You can receive a copy of your records, [DETAIL ON HOW TO REQUEST RECORDS]. Professional records can sometimes be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so we can discuss the contents.

Confidentiality

All our work together—our conversations, your records, and any information you give me—is protected by something called privilege. That means the law protects you from having information about you given to anyone without your awareness and permission. However, there are some limits to your legal privilege, which you should understand before we start:

If I have reason to believe there is a risk you might harm yourself or someone else, I am required to contact the authorities or the other person to give them the opportunity to protect you or themselves. If you are abusing children or elderly people [IF APPLICABLE BASED ON THE LAWS OF THE STATE OR JURISDICTION], I am required by law to notify the authorities so they can protect others from harm.

Your signature below indicates that you have read the information in this document, had opportunities to ask questions about its contents, and agree to abide by its terms for the duration of your therapy.

Patient's Signature and Date

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