ASSESSMENT AND TREATMENT OF OBSESSIONAL HARASSMENT

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ABSTRACT. Obsessional harassment and stalking have become increasingly recognized as significant social problems, often with dramatic negative repercussions on the lives of victims. As the public awareness of this problematic behavior has grown, the amount of clinical attention and empirical research focused on understanding the perpetrators of harassment has increased accordingly. Nevertheless, relatively little research has addressed the numerous issues involved in the assessment and treatment of obsessional harassment offenders. This article reviews the existing research on obsessional harassment/stalking, and offers a diagnostic typology of these offenders based on the nature of the relationship with the victim and the motivation of the offender. Treatment modalities are then discussed with regard to each of the primary diagnoses that occur among obsessional harassment offenders. Finally, strategies for initiating treatment for unmotivated or unwilling offenders are discussed, along with clinical issues that arise in the evaluation and treatment process. © 2000 Elsevier Science Ltd. All rights reserved.

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STALKING AND OBSESSIONAL HARASSMENT are terms that have become an increasingly common part of our contemporary vernacular as public attention to, and fear of this behavior, continues to grow. Numerous labels have been used to describe the phenomenon in which an individual, for whatever reason, repeatedly initiates contact with, or monitors the actions of an unwilling individual. Most investigators define this behavior as the voluntary and repetitive following of or initiating contact with another person that causes fear or a significant disruption in his or her life. Whether termed “stalking,” obsessional following, erotomania, or De Clerambault’s Syndrome, individuals who have been subjected to this behavior report feelings ranging from annoyance to trauma (Mullen & Pathe, 1997). Among these numerous terms and descriptors, I prefer obsessional harassment for several reasons. First, not all “stalkers” actually stalk, or follow their victims. Many use telephone contact, mail, or other methods of communication...
which involve no direct, face-to-face contact. Other terms, such as erotomania or De Clerambault’s Syndrome, reflect only one diagnostic subgroup of obsessional harassment offenders, and therefore may accurately describe this subgroup of offenders, but not the behavior of obsessional harassment more generally. Obsessional harassment, on the other hand, accurately characterizes the repetitive nature of the perpetrator’s preoccupation (i.e., obsessional) as well as the perception of victims (harassment), regardless of whether direct or indirect contact is involved. Nevertheless, to retain consistency with common usage, as well as legal definitions, the term stalking will be used where appropriate with the acknowledgment that both terms are intended to reflect essentially the same patterns of behavior.

Like the wide array of terms and definitions used to describe obsessional harassment, legal definitions of stalking or obsessional harassment also vary across different jurisdictions. Most legal definitions closely approximate, albeit usually with greater specificity, the definition above, in which repeated contact, such as following or loitering near an individual, repetitive or unwanted telephone calls, letters or gifts, and/or a general interference with one’s routine or relationships with other individuals is classified as harassment. Testimony to the rapidly growing public concern regarding stalking and obsessional harassment is evident in the wave of “anti-stalking” legislation that has passed in all 50 states within the past decade (Anderson, 1993; Flynn, 1993; Fritz, 1995). These statutes typically impose increasingly severe penalties for repeated harassment, often leading to felony charges for harassment that 10 years ago would have resulted in a veritable “slap on the wrist.”

One of the major causes for concern over obsessional harassment is the fear that relatively mild forms of harassment will escalate into potentially dangerous behaviors. Indeed, many cases of obsessional harassment begin with relatively benign forms of contact, (e.g., telephone calls or letters). Gradually, when initial overtures are not met with a satisfactory response, these individuals may progress to more intrusive or frequent behaviors, such as direct face-to-face encounters, or loitering near the victim’s home or workplace. Threats or actual violence occur in only a subset of cases in which obsessional harassment occurs, a fact that is either reassuring or frightening, depending on one’s interpretation of the data. Meloy (1996), for example, estimated that 50% of individuals who engage in obsessional harassment eventually make threatening statements and 25% initiate an actual assault (very few of these assaults, however, are life threatening). However, because estimates of the frequency with which harassment leads to assault are often based on samples of incarcerated offenders, the accuracy of such statistics when applied to the broader population is questionable.

As public and political attention to the problem of stalking and obsessional harassment has grown, an increasing number of mental health clinicians have begun to study this seemingly pathological behavior. Numerous attempts to characterize obsessional harassment offenders has resulted in the same conclusion: these individuals comprise a heterogeneous group and no single “profile” can adequately describe such a diverse population. Instead, what has emerged from these data is a general typology of harassment with different characteristics corresponding to the disparate types of offenders. This diversity is no doubt related to the volume of individuals engaged in obsessional harassment. The results of a large scale national survey (Tjaden & Thoennes, 1998) estimated that approximately 1,000,000 woman and 370,000 men had been stalked in the preceding year and nearly one in twelve women would likely be stalked at some point during their lifetime. Given the apparent magnitude of this problem, determining who engages in this behavior and how to best treat these individuals has become an increasingly important undertaking.
Who Stalks?

One of the principle questions posed to mental health professionals has been to understand why an individual develops a pattern of obsessional harassment. In other words, what form of personality or mental disorder(s) lead an individual to become obsessed with another person, despite all evidence that a relationship is not desired? Clinical observation and empirical research have delineated several types of obsessional harassment offenders based on a combination of factors, such as the identity of the victim (e.g., intimate, celebrity, politician, employer), the nature of the relationship (real or fantasy), and the individual’s motivation (romantic or revenge).

One level of analysis in understanding the “types” of obsessional harassment focuses on the identity of the victim of the harassment, a factor that is often linked directly to the motivation of the offender. One of the most common “types” of obsessional harassment offenders, albeit the least publicized, is former intimates, such as an ex-spouse or ex-lover (Tjaden & Theonnes, 1998; Flynn, 1993). These cases are usually dominated (although not exclusively) by abusive husbands who use harassment along with intimidation and even threats of suicide or homicide to maintain or re-establish a relationship. Domestic violence research indicates that roughly 30% of female homicide victims are killed by former intimates who had stalked or harassed them prior to their death (Fritz, 1995). Tjaden and Theonnes (1998) reported that more than half of the women in their survey who reported having been stalked indicated having had a prior intimate relationship with the offender. Moreover, of women stalked by a former intimate, more than 80% reported a history of violence in the relationship. Cases of stalking by former intimates, however, are rarely publicized as the victims are often not of a social status that affords them publicity or at times even adequate protection.

The fear that an over-zealous ex-boyfriend or spouse’s attempts to resume a relationship will become obsessional harassment may result in some confusion between normal and pathological interpersonal behavior. Admittedly, distinguishing pathological and non-pathological behavior in the context of a failed relationship is a difficult, if not impossible task, and often rests primarily on the reaction of the victim. Therefore, as public awareness of stalking and harassment grows, many individuals characterize any attempt to renew a failed relationship as harassment. This tendency to over-pathologize behavior is evident in a recent study of college students in which 30% of female and 15% of male college students reported having been the victim of “stalking” behavior (Fremouw, Westrup, & Pennypacker, 1997). Statistics that quite likely reflect an overly broad interpretation of stalking. Interestingly, only 1% of students acknowledged having engaged in this behavior, a finding which the authors attribute to the social undesirability of harassment, but which may also reflect biased perceptions on the part of the respondents (i.e., perceiving the same behavior as rational in oneself yet pathological in others). Nevertheless, given the potential for severe harm, it is clear that unwanted advances by former intimates must be dealt with clearly and directly in order to distinguish real from imagined cases of obsessional harassment.

A second group of individuals that account for a substantial proportion of obsessional harassment cases are the fans or followers of public figures. Celebrities, athletes, and politicians often encounter, among their legion of fans, a small group who become preoccu-

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1 In fact, this male-female difference in rates of harassment is significantly lower than that reported in most studies, in which more than 75% of “stalkers” are typically found to be male. Estimates based on official statistics such as arrests, however, likely over-estimate the proportion of males engaging in obsessional harassment as women are presumed to be more likely to report this behavior than are men.
pied or even obsessed with them. When carried to an extreme, these individuals may express amorous feelings towards the object of their attention without realizing that their feelings are not reciprocated. Like the behavior of former intimates, many individuals engaging in this type of harassment display behaviors that might be seen as appropriate if the fantasized relationship did in fact exist (e.g., frequent letters, telephone calls, flowers, gifts). Some of these individuals, however, are aware that their affection is not reciprocated and their behavior is often more disturbed (e.g., loitering in the vicinity of their target; collecting numerous, often bizarre souvenirs or memorabilia). Estimates of the proportion of individuals who develop these pathological attachments is also a difficult, if not impossible undertaking. Yet, most well-known public figures have encountered this phenomenon in one form or another and the frequency is often proportional to their level of celebrity.\textsuperscript{2} A recent study of letters written to Hollywood celebrities noted that tens of thousands of such communications were collected by one large security firm alone (Dietz et al., 1991b).

A third group which accounts for a substantial number of obsessional harassment incidents is comprised of individuals who perceive themselves to be the victims of unfair treatment. These persons typically harbor intense anger and resentment over what they perceive as unfair or inappropriate behavior on the part of others. Politicians and judges appear particularly vulnerable to this form of harassment, although employers, police officers, and other authority figures may become the victims as well. Unlike the two previous forms of harassment, these individuals are typically motivated by revenge rather than affection. As such, the frequency of overt threats is substantially greater among this population compared to other subgroups of obsessional harassment offenders. Dietz et al. (1991a), in their review of inappropriate letters sent to political figures, many of whom were motivated by revenge rather than affection, found that 58% of the authors of this correspondence had made overt threats of violence in their communications.

\textbf{Why (Diagnostically) Do Individuals Stalk?}

In addition to focusing on the motivations behind obsessional harassment, mental health clinicians have directed their attention to exploring the psychiatric symptoms and clinical syndromes that may result in this disturbing behavior. Although much of the early clinical literature focused primarily on a single syndrome, erotomania or De Clerambault’s syndrome (described below), as the basis for obsessional harassment (e.g., Fritz, 1995; Goldstein, 1978; Leong, 1994), more recent research has revealed a number of different diagnostic entities that may correspond to obsessional harassment. Meloy (1989), for example, classified stalkers as either erotomanic or “borderline erotomanic,” applying the latter term to individuals who are obsessed with another but are aware that their feelings are not reciprocated. This method of categorizing offenders, however, groups individuals with widely divergent mental disorders together under a single label (e.g., schizophrenia, depression, personality disorder). Moreover, this dichotomy ignores non-amorous motivations for harassment, such as anger and revenge, which are not accurately categorized by the term “erotomanic.”

Because the effectiveness of alternative interventions likely differ depending on the diagnosis of the individual offender, an accurate assessment and diagnosis must be made before appropriate recommendations can be offered. A wide range of psychiatric disorders have been associated with obsessional harassment (e.g., Harmon, Rosner & Owens, 1995; Harmon et al., 1995).

\textsuperscript{2}The potential for a fantasied (i.e., delusional) attachment does not exclusively occur among celebrities or public figures, however, the prevalence of such attachments to non-public figures is considerably smaller.
Meloy & Gothard, 1995). The most common diagnoses observed among obsessional harassment offenders, which are discussed in detail below, include delusional disorders, schizophrenia, mania, and personality disorders. Although some generalizations may be made regarding the type of disorder most likely to correspond to a given form of harassment, one must be wary of the potential for overlap among both diagnostic categories and offender types.

Delusional Disorders

Delusional disorders are defined by DSM-IV (American Psychiatric Association, 1994) as “non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, of deceived by a spouse or lover, or having a disease)” that do not occur in the context of a more pervasive mental disorder (e.g., schizophrenia or mood disorder), and do not result in grossly impaired functioning or bizarre behavior (apart from the direct impact of the delusion(s) or its ramifications) (p. 301). Although the DSM-IV describes several types of delusional disorders, two of these variants appear more likely to occur in cases of obsessional harassment, the erotomanic and persecutory types.

Erotomania, or De Clerambault’s syndrome, is characterized by a delusion that another person, usually of higher social or professional status, is in love with the individual. This disorder occurs more frequently among individuals who become obsessed with celebrities and other well-known public figures, and often results in highly publicized cases in which individuals believe that they are romantically involved with, or even married to celebrities with whom they have no genuine relationship. Prior to the recent surge of public and professional interest in obsessional harassment, erotomania was considered a rare disorder primarily afflicting women (Munro & Mok, 1995). More recent attention, however, has revealed a considerably higher prevalence of erotomania than once thought, at least among samples of obsessional harassment offenders. Estimates of the frequency of erotomania among samples of individuals charged with or convicted of obsessional harassment ranges 10–30%, and include a substantial proportion of males, a population that had been virtually absent from nonforensic samples (Harmon et al., 1995; Meloy, 1996). Despite the disturbing and sometimes bizarre behavior of erotomaniac individuals, the frequency of violent behavior among this subgroup of offenders appears lower than among other diagnostic categories. Dietz et al. (1991b), for example, found that only 23% of individuals who harassed Hollywood celebrities made threats of any type in their correspondence, and a substantial proportion of these “threats” were considered implausible (e.g., placing a hex or curse on the target). Moreover, they found no relationship between threats of violence in the correspondence and actual attempts to initiate direct contact with or harm the target of the harassment. A relatively lower frequency of threats or violence among this subgroup of offenders is likely a reflection of the amorous motivation of erotomaniac individuals in which their goal is to maintain or resume a relationship. Thus, while the likelihood of threats directed at the target of their harassment may be less common than among other diagnostic groups, risk of violence also exists for third parties who may be perceived as hindering their relationship.

Delusional disorder, persecutory type, involves a delusion that one is being mistreated or harmed in some way when no evidence to support this perception exists. Although this disorder was observed less frequently than erotomania in the early clinical literature on obsessional harassment, several findings suggest that persecutory delusions may be a frequent basis for harassment that is motivated by anger or revenge. An example of nonbizarre, persecutory delusions was observed by this author in evaluating a defendant
who had been arrested after allegedly making threats to harm a federal court judge. This individual had reportedly become “obsessed” with a civil lawsuit (and appeal) which he had lost, threatening to exact revenge against the judges who had ruled against him. Research by Dietz et al. (1991a) also supports the possible presence of paranoid delusions as the basis for obsessional harassment. These authors found that the majority of individuals who harassed United States Congressmen expressed primarily paranoid and angry themes rather than amorous themes, with anger and retribution as the principle motive behind the harassment, indicating that prominent symptoms of paranoia are likely present among a subset of obsessional harassment offenders. Moreover, as noted above, Dietz et al. (1991a) found a high rate of threatening correspondence among this sample, with at least one threat occurring in 58% of the cases studied.

**Psychotic Disorders**

In addition to individuals with specific, non-bizarre delusions in the absence of other psychotic symptoms, a number of obsessional harassment offenders have delusional beliefs that occur in the course of a more pervasive psychotic disorders (e.g., schizophrenia, bipolar disorder). The disorders most commonly linked to bizarre, repetitive behaviors and/or delusional beliefs are schizophrenia, bipolar disorder, and schizo-affective disorder. Erotomanic delusions are also observed occasionally among grossly psychotic individuals. Gillet et al. (1990) described this phenomenon, in which erotomanic delusional beliefs were a symptom of a more pervasive disorder, as “secondary erotomania,” a term rooted in De Clerambault’s early writings on erotomania [see (Goldstein, 1998)].

In addition to those individuals who have erotomanic delusions as part of a more pervasive psychotic disorder, other symptoms may lead psychotic individuals to engage in obsessive harassment. Psychotic individuals may develop an obsessive fixation on the target of their harassment without being in love with that individual. For example, one obsessional harassment offender who is well-known to the New York City Criminal Court system described a delusional belief that a popular singer had placed him under a spell, compelling him to repeatedly seek her out and loiter outside her building despite her protestations. Despite numerous arrests, this individual denied any romantic fixation on this woman, attributing his bizarre behavior to “witchcraft.” Paranoid schizophrenic individuals may also become obsessively fixated on an individual whom they perceive to be responsible for their problems or difficulties, despite the lack of any direct or rational basis for their paranoia. Another individual referred to the author for evaluation was arrested for harassment after he allegedly made threatening telephone calls to a judge who had “unfairly” ruled against him in a multimillion dollar civil suit. This lawsuit, however, was based on the defendant’s allegation that he had been unjustly denied insurance benefits after his own death several years ago.

Although the frequency of violence among psychotic individuals has been widely debated, the presence of persecutory delusions in an individual who is grossly psychotic is likely to substantially increase the risk of violent behavior (Link & Steuwe, 1994; Monahan, 1992). Other factors that increase the likelihood of violence among individuals with schizophrenia or bipolar disorders include the concurrent presence of substance abuse, evidence of antisocial behavior unrelated to the harassment, and a prior history of violence [e.g. (Monahan, 1992)]. In the absence of these additional risk factors, the likelihood of violence, even among psychotic obsessional harassment offenders, may not exceed the risk of violence among the general population.
Personality Disorders

Another common explanation for obsessional harassment is the presence of one or more personality disorders. Dependent, paranoid, borderline, narcissistic, and antisocial personality disorders all occur among obsessional harassment offenders either alone or, more commonly, in various combinations (Kienlen, Birmingham, Solberg, O’Regan, & Meloy, 1997; Meloy & Gothard, 1995). For example, a substantial body of literature has focused on dependency issues and dependent personality disorders in violent relationships [e.g., (Hamberger & Hastings, 1988; Murphy, Meyer, & O’Leary, 1994)], and these relationships may evolve into cases of obsessional harassment when one party refuses to accept the termination of the relationship. Because of the frequent occurrence of violence in the course of these relationships [e.g., (Tjaden & Theonnes, 1998)], the potential for further, sometimes severe violence is substantial in these offenders. Unfortunately, the lack of obvious psychosis in these offenders may be interpreted by some clinicians as indicating a diminished risk of violence when such comfort is rarely justified.

Paranoid, narcissistic, and borderline personality disorders appear more likely among revenge-motivated harassment offenders. Individuals with paranoid personality disorders are prone to perceive harm or exploitation in work situations and interpersonal relationships, often becoming angry and resentful over perceived mistreatment. Unlike individuals with a delusional disorder, however, those with a paranoid personality disorder typically base their paranoid beliefs on a misinterpretation of actual events rather than having a blatantly false (i.e., delusional) basis for their anger. Therefore, harassment is typically directed at individuals with whom the perpetrator had a genuine relationship such as former employers or co-workers, judges, or other public officials, rather than developing a fixation on individuals with whom no actual relationship existed. Similarly, individuals with borderline personality disorders may become excessively angry over a perceived wrongdoing, and are prone to impulsive and inappropriate behaviors during stressful periods, heightening the risk of dangerous behavior during the course of harassment. Meloy (1998) has also posited narcissism as a core element of obsessional harassment, suggesting that these offenders have a “narcissistic linking fantasy” in which they feel connected to an idealized object. Empirical support for this hypothesis is still quite limited although a diagnosis of narcissistic personality disorder has been observed studies of obsessional harassment offenders [e.g., (Kienlen et al., 1997)].

Another personality disorder occasionally found among individuals engaged in obsessional harassment is antisocial personality disorder. These individuals typically engage in harassment to fulfill their desire to instill fear or inflict harm on another, rather than because of a desire to resume a relationship or right a perceived wrong. Antisocial personality disorders, however, appear relatively infrequently among obsessional harassment offenders and may be more often observed in the presence of another primary diagnosis such as substance abuse or a psychotic disorder (e.g., Harmon et al., 1995; Kienlen et al., 1997; Meloy & Gothard, 1995). For example, many individuals who harass former intimates because of an inability to accept rejection likely display a combination of dependent, borderline, and antisocial personality traits, with this combination resulting in a tendency to use threats, intimidation, or even violence as a mechanism for maintaining the relationship and avoiding abandonment. Moreover, because these individuals often lack reservations against acting out their threats and innuendo, the potential for dangerous behavior is considerable when the diagnosis of antisocial personality disorder is present.

Other Mental Disorders

Substance abuse and dependence have been frequently observed among individuals who engage in obsessional harassment although rarely diagnosed as the primary disorder
The presence of substance abuse among these individuals is relevant in several regards, but principally due to the increased risk of violence. A growing body of research has demonstrated that substance abuse, particularly when occurring in conjunction with another mental disorder, substantially increases the likelihood of violent behavior, in part because of the decreased inhibitions against acting out aggressive impulses (e.g., Monahan, 1992; Steadman et al., 1998). These findings, developed through large-scale studies of mentally disordered individuals, have been supported by research with obsessional harassment offenders. Harmon et al. (in press) found that, among criminal defendants charged with crimes resulting from obsessional harassment, the groups most likely to have engaged in a violent incident during the course of their harassment were those diagnosed with substance abuse along with another major mental disorder. Thus, while substance abuse may not lead to obsessional harassment directly, this behavior appears to substantially increase the likelihood of violence. Moreover, the potential utility of any clinical intervention is likely attenuated unless concurrent substance abuse issues are addressed as well. Without effective treatment for substance abuse, obsessional harassment offenders are unlikely to be either compliant or motivated to address their problematic behaviors.

Another disorder that has been rarely described in reference to obsessional harassment, yet may nevertheless have clinical relevance, is obsessive-compulsive disorder. Clinical reports have suggested that obsessive-compulsive disorder may at times be confused with delusional disorders (Kozak & Foa, 1994; Opler, Klahr, & Ramirez, 1995; Solyom, DiNicola, Phil, Sookman, & Luchins, 1985; Sondheimer, 1988). For example, Solyom et al. (1985) describe a variant of obsessive-compulsive disorder “bordering on the delusional,” yet without other psychotic symptoms, and suggest the term “obsessive psychosis” as a diagnostic entity that may account for these individuals. Because the obsessive nature of many stalkers (including both psychotic and nonpsychotic individuals) bears such a strong resemblance to the behaviors and attitudes of individuals with obsessive-compulsive disorder, this disorder may be more relevant than clinicians have typically realized. Although obsessive-compulsive disorder is virtually never diagnosed in clinical samples of obsessional harassment offenders, this absence may be more a reflection of clinician oversight than true estimate of the prevalence of this disorder. Further research and clinical assessment with a focus on the potential relevance of obsessive-compulsive symptoms may reveal a substantially higher prevalence of this syndrome than has been reported.

**PREVALENCE OF VARIOUS DIAGNOSTIC CATEGORIES**

Estimates of the frequency of various diagnostic categories and “types” of obsessional harassment offenders have come from a number of different sources, but the empirical research to date has primarily focused on arrested or incarcerated individuals. In one of the first published studies of obsessional harassment, Zona et al. (1993) studied records compiled by the Los Angeles Police Department. They found 74 cases that demonstrated “an obsessional or abnormal long-term pattern of threat or harassment directed toward a specific individual” (p. 896) and categorized offenders into three categories: (1) those with a delusional disorder, typically erotomanic type, in which no genuine relationship with the target of their harassment existed; (2) a “love obsessional” group in which erotomanic delusions or obsessive preoccupation was viewed as a symptom of another primary diagnosis (e.g., schizophrenia, bipolar disorder); and (3) a “simple obsessional group” in which a relationship existed between offender and victim prior to the harassment. The latter category was thought to include primarily individuals diagnosed with personality
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disorders and/or substance abuse. The authors found 7 of their 74 cases (9.5%) that fit the classification of “erotomanic,” 32 cases (43.2%) classified as “love obsessional,” and 35 (47.3%) that fit the “simple obsessional” category. These classifications, however, were made on the basis of available legal data (e.g., police records) and no direct clinical evaluations of the offenders were conducted.

Harmon, Rosner, and Owens (1995) utilized a somewhat different methodology in their retrospective analysis of obsessional harassment offenders. They reviewed records of criminal defendants referred for a court-ordered psychiatric evaluation and compared defendants who were defined as having engaged in obsessional harassment (N = 48) with defendants charged with other offenses. Their findings with regard to offender characteristics and diagnostic categories revealed many similarities to the typology suggested by Zona et al. (1993), but with somewhat different rates of each “type.” For example, they found a high rate of delusional disorder diagnoses among obsessional harassment offenders, with 29% (n = 14) diagnosed with this disorder. Erotomanic defendants (n = 6) comprised only one subgroup of those with delusional disorders, as several defendants (n = 3) were diagnosed with a delusional disorder, persecutory type, and an additional 3 defendants displayed a mixture of erotomanic and persecutory delusions (2 of the 14 defendants diagnosed with delusional disorders could not be classified with regard to the type of delusion). Harmon et al. (1995) found an additional 21% of subjects (n = 10) diagnosed with schizophrenia and 10% with psychotic disorder not otherwise specified, yielding a total of 60% of defendants diagnosed with some psychotic disorder. The most common diagnoses ascribed, other than psychosis, were personality disorders, comprising 19% (n = 9) of this sample. The remaining 10 subjects were diagnosed with a range of different diagnoses including organic mental disorder (n = 2), adjustment disorder (n = 4), mood disorder (n = 1), substance abuse (n = 1), “unspecified mental disorder” (n = 1), and none (n = 1).

In an extension of their earlier study, Harmon et al. (1998) found a similar pattern of results, with psychotic disorders accounting for nearly 40% of 175 individuals classified as having engaged in obsessional harassment. Their sample included 27 individuals (15%) diagnosed with delusional disorders and 42 (24%) diagnosed with schizophrenia or other psychotic disorders (e.g., psychotic disorder not otherwise specified). Interestingly, the largest diagnostic group found in this expanded sample of offenders were individuals diagnosed with personality disorders, accounting for nearly one third of the entire sample (n = 56). Other common diagnoses included substance abuse disorders (present in 36 cases or 21% of the sample) and adjustment or mood disorders (n = 36, 21%).

Meloy and Gothard (1995) reported a somewhat lower frequency of delusional disorder in their sample of 20 criminal defendants who were evaluated in a forensic psychiatric clinic. These authors found only 2 patients ascribed delusional disorder diagnoses (10%), both of whom were diagnosed with erotomanic type. Unlike other studies [e.g., (Harmon et al., 1995, in press)], their sample was predominantly comprised of individuals with personality disorders and substance abuse. Eighty-five percent were diagnosed with a personality disorder, typically mixed type, and 35% were diagnosed with a substance abuse or dependence disorder. Interestingly, despite the high rate of personality disorder diagnoses in this sample, only two subjects (10%) were diagnosed with antisocial personality disorder.

The data accumulated to date, while clearly limited by small and possibly biased (i.e., non-representational) samples, suggest a potential diagnostic typology (Table 1) with different psychiatric diagnoses corresponding to different “types” of stalking. Considerable support exists to demonstrate that individuals with either a delusional disorder or delusional symptoms secondary to a primary psychotic disorder (e.g., schizophrenia or mania) are responsible for a considerable proportion of the “high profile” cases of obsessional
TABLE 1. A Diagnostic Typology of Obsessional Harassment

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<th>Motive</th>
<th>Nature of Relationship</th>
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<td>Real</td>
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<td>Love</td>
<td>Dependent/Borderline Personality</td>
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<td>Psychotic/Mood Disorder</td>
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<td>Delusional Disorder, Persecutory</td>
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<td>Psychotic Disorder</td>
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harassment such as those recounted in newspaper and magazine articles. Psychotic individuals also, however, appear to be at risk for more than one type of “stalking” behavior, as individuals with paranoid schizophrenia or delusional disorder, persecutory type occasionally develop a fixation on individuals whom they perceive as having harmed them in some way. A sizable proportion of obsessional harassment cases do not appear related to any psychotic disorder or delusional beliefs, but rather emerge in the context of an estranged romantic relationship or other genuine interpersonal relationships (e.g., employment, legal). Such individuals tend to be diagnosed with personality disorders (although not necessarily antisocial), and may often have a history of substance abuse. The latter cases, however, are unlikely to generate the media attention that has recently surrounded the phenomenon of stalking. Nevertheless, for the victim of this harassment, clinical intervention to prevent continued harassment and minimize the risk of harm is clearly necessary.

TREATMENT APPROACHES FOR OBSESSIONAL HARASSMENT OFFENDERS

Given the frequency with which obsessional harassment offenders resume their harassment after arrest and/or incarceration (e.g., Flynn, 1993), even with the presence of orders of protection (Meloy, Cowett, Parker, Hoftland, & Friedland, 1997), many victims of harassment desire mental health treatment for these offenders. However, one limiting factor in assessing the efficacy of treatment alternatives for obsessional harassment is that there are no treatments specifically designed to address this problematic behavior. That is, there are no published studies, or even case reports, of successful treatment approaches for obsessional harassment. This apparent shortcoming is not necessarily surprising, given the consistent finding that obsessional harassment can be a symptom of many different psychiatric disorders, but is not a disorder per se. Thus, treatment of individuals who engage in obsessional harassment must address the underlying disorder, not simply focus on the problematic behavior itself. Nevertheless, some interventions focused specifically on the target symptoms such as erotomanic delusions or obsessive behaviors may be effective in changing the behavior patterns of obsessional harassment offenders. Despite the lack of research directly addressing treatment of obsessional harassment offenders, a number of treatment recommendations are outlined here based on published data for individuals with similar diagnoses. These recommendations are largely extrapolated from case reports and clinical suggestions regarding the treatment of similar patients, typically without any formal identification of these individuals as having engaged in obsessional harassment.

“Primary” Delusional Disorders

Over the past several decades, the principle focus of treatment for individuals with delusional disorders has been pharmacological interventions. For many years, clinical lore
suggested that antipsychotic medications were largely ineffective in the treatment of delusional symptoms (Opler et al., 1995). This conclusion was considered even more pronounced among individuals with delusional disorders, as these individuals lack the florid psychotic symptoms that are most likely to respond quickly to antipsychotic medications (e.g., thought disorder, hallucinations). More recently, however, a growing literature has suggested that delusional disorders may in fact respond favorably to antipsychotic medications. For example, Gillett, Eminson, and Hassanyeh (1990) described the results of a series of case studies in which patients with erotomanic delusions were treated with pharmacological interventions, specifically pimozide (Orap), an antipsychotic medication. They found a mixed response among the subset of 3 patients with delusional disorders, with 1 patient demonstrating substantial improvement in his delusional fixation, another demonstrating continued delusional symptoms but with less intensity and intrusiveness, and a third with virtually no response to pharmacological treatment. Unfortunately, the patient who demonstrated the most improvement on pimozide subsequently relapsed when medication was discontinued.

Munro and Mok (1995) reviewed the literature on treatment of delusional disorders, incorporating findings from 30 years of research and case studies. Of note, these authors found that, of all patients diagnosed with delusional disorder, relatively few were classified as erotomanic (11%) or persecutory types (6%). Their analysis demonstrated that the antipsychotic pimozide was significantly superior to other neuroleptics in resolving delusional disorders. Their review revealed that 7 of 14 patients (50%) with nonsomatic delusional disorders (erotomanic, persecutory, and jealous types) demonstrated “recovery” when treated with pimozide and an additional 5 patients showed a partial recovery (36%). Only 2 of these 14 (14%) patients treated with pimozide showed no improvement. Conversely, 13 of 26 patients (50%) treated with other antipsychotic medications showed no improvement, while only 8 of 26 (31%) were considered recovered and 5 (19%) showed partial recovery. They concluded, on the basis of this review, that pimozide was the treatment of choice for patients with delusional disorders.

Despite these encouraging findings from studies of antipsychotic medications, the applicability of these conclusions to the treatment of delusional patients who engage in obsessional harassment is limited by several factors. First, the patients described in reports of treatment for delusional disorders are typically clinical samples, not forensic samples. As such, it is likely that many patients sought treatment voluntary, a level of treatment motivation uncommon among individuals who engage in obsessional harassment. Given that the success of any pharmacological intervention is limited by the patient’s medication compliance, the issue of motivation for treatment is significant. Because many patients with delusional disorders lack insight into the delusional basis for their belief system, voluntary medication compliance is unlikely. Nevertheless, these results offer some encouragement for victims of erotomanic offenders as their delusional beliefs may respond to pharmacological interventions if treatment can be initiated.

Psychological interventions have also been considered futile in resolving delusional beliefs. Many clinicians have presumed that psychotherapeutic interventions for psychotic symptoms were ineffective and possibly even inappropriate, and have attributed any suggestion otherwise to the residual influence of psychoanalytic thinking. Although little empirical data have arisen to contradict these assumptions, several authors have proposed psychological interventions for delusional beliefs and delusional disorders. For example, Alford and Beck (1994) described the application of cognitive therapy principles to the treatment of delusional beliefs, albeit without any formal assessment of the effectiveness of this approach. Beary and Cobb (1981) demonstrated the utility of operant conditioning principles to the treatment of delusional disorders, although the focus of their treatment...
was on patients with somatic rather than erotomanic or persecutory delusions. The applicability of this literature to the treatment of obsessional harassment offenders is presently unknown but likely also hinges on patient motivation. Further research on the efficacy of psychotherapy approaches to the treatment of delusional beliefs is clearly warranted.

Other Psychotic Disorders

As noted earlier, the most common diagnoses in which delusions and obsessive fixations occur as a symptom are schizophrenia, schizo-affective disorder, and bipolar disorder. Thus, treatment decision-making will differ depending on the mental disorder presumed to underlie the obsessional harassment. Antipsychotic and mood stabilizing medications are often effective, either alone or in combination, in resolving the delusional symptoms of patients with schizophrenic or mood disorders (Opler et al., 1995). Gillett et al. (1990), for example, found that erotomanic delusions that had been present in two manic patients resolved completely after treatment with pimozide and lithium, and did not recur even during subsequent manic episodes. A third manic patient with erotomanic delusions, however, showed no improvement in his/her delusions even after other symptoms of mania remitted. These authors also found a limited response to antipsychotic medication among four schizophrenic patients and one schizo-affective patient, all of whom had erotomanic delusions. They found that treatment resulted in some decrease in the intensity of the delusion, but these beliefs remained intact nonetheless. Similarly mixed results have typically been reported for psychotic patients with primarily persecutory delusions (e.g., individuals with paranoid schizophrenia), with some patients responding favorably to antipsychotic medications and others who do not.

The occasional connection between mood disorders and erotomanic delusions have also led some investigators to seek alternative interventions beyond antipsychotic medications. Remington and Jeffries (1994) described a series of case studies using electroconvulsive therapy (ECT) to treat patients with erotomanic delusions who were diagnosed with mood disorders. They found that, among their sample of three patients who had not responded to previous somatic therapies, two demonstrated a “resolution of the erotomanic delusions,” while the third showed a slight, transient improvement. These authors concluded that ECT may be an effective alternative in the treatment of erotomanic delusions related to mood disorders. This conclusion has been supported by other reviewers who have suggested that ECT may be effective in resolving various types of delusions secondary to affective, psychotic, and organic disorders (Fink, 1995).

Psychotherapeutic interventions have also been suggested as adjunctive treatments for delusions in patients with schizophrenic and mood disorders. Several authors have described the application of cognitive therapy principals to the treatment of delusions in patients with schizophrenia [e.g., (Chadwick & Lowe, 1990, 1994; Jacobs, 1980; Jenson & Kane, 1996)]. Others have suggested behavioral techniques based on operant conditioning principles for the treatment of delusions [e.g., (Corrigan & Storzbach, 1993)]. These reports, however, often lack systematic outcome data to evaluate the treatment success of these approaches. One exception has been the work of Chadwick and Lowe (1990, 1994), which demonstrated a reduction in the several measures of delusional beliefs in patients with schizophrenia using cognitive-behavioral and psycho-educational interventions. These authors described treatment success in several cases, ranging from complete “rejection” of their previous beliefs to a decreased level of conviction. Again, however, the comparability of these samples and the applicability of these methods to obsessional harassment offenders is unknown.
**Personality Disorders**

The efficacy of treatment for individuals with personality disorders varies considerably according to both the type of personality disorder and the type of intervention; however, these disorders are generally more difficult to treat than most major mental disorders [see (Gabbard, 1995; Rosenbluth, 1996)]. While no research has directly assessed the use of mental health interventions to treat obsessional harassment due to personality disorder, a large body of research has emerged on treatment approaches for domestic violence, and considerable overlap exists among these two groups of offenders (obsessional harassment offenders diagnosed with personality disorders and male spouse abusers). The general conclusion of this large body of research is that treatment is sometimes effective, but only among patients who are motivated to change their abusive behavior. Rosenfeld (1992) reviewed the literature on the treatment of spouse abuse, and found that court-ordered treatment was occasionally effective, but no more so than traditional legal system interventions such as arrest and incarceration. He concluded that legal system interventions (e.g., incarceration) may be more appropriate than many of the clinical approaches offered, particularly as treatment often added no incremental benefit above and beyond the deterrent effects of arrest and incarceration. This finding is consistent with the observations of many clinicians regarding the benefits of legal system interventions for obsessional harassment offenders that emerge in the context of domestic violence. Meloy (1997), for example, suggested that this subgroup of offenders is most likely to cease their obsessional harassment following arrest or incarceration, while such interventions are typically ineffective in the psychotic offender.

**Substance Abuse**

The dilemmas posed by substance abuse disorders among obsessional harassment offenders, particularly when superimposed on other mental disorders, are significant. Despite the importance, therefore, of addressing substance abuse in patients who engage in obsessional harassment, a review of available treatment approaches for this disorder is beyond the scope of this chapter. A large and growing body of research, however, demonstrates a substantial increase in the risk of violent or other inappropriate behaviors when individuals abuse drugs or alcohol (Steadman et al., 1998; Swanson, 1994). Thus, treatment approaches that simultaneously address substance abuse along with other symptoms or disorders are needed whenever this behavior appears linked to cases of obsessional harassment. Without coordinated treatment, the success of other therapeutic interventions is likely to be limited and the risk of violent or dangerous behavior substantially increased.

**Obsessive Compulsive Disorders**

The utility of behavioral and cognitive-behavioral interventions for the treatment of obsessive thoughts and compulsive behaviors is well established (Franklin & Foa, 1998). Given the possibility that obsessional harassment may at times reflect a variant of obsessive-compulsive disorders, the potential for these interventions is clear. Moreover, a growing number of pharmacological interventions are available for obsessive-compulsive disorders (e.g., clomipramine, fluoxetine), and these medications may be effective in patients whose primary obsessive trait is harassment. To date, however, no research has addressed the utility of these medications for obsessional harassment.
A number of different factors complicate the assessment and treatment of obsessional harassment offenders, including patient and clinician variables which complicate the assessment and treatment process (e.g., denial/minimization on the part of patients, countertransference reactions on the part of therapists) as well as systemic factors which hinder attempts to secure treatment (e.g., limited mechanisms to mandate or monitor treatment). Accurately assessing obsessional harassment offenders, and more importantly, diagnosing the symptoms underlying obsessional harassment behavior, can often be a complex task that requires efforts that are often unnecessary in typical clinical evaluations. In addition, clinicians may experience countertransference in treating potentially dangerous individuals and potentially unaware of the impact of their fears on the treatment process, or if aware, unwilling to take these feelings into account in modifying their treatment approach. Finally, the difficulties in assessing the efficacy of treatment must be considered, particularly as these issues are influenced by the context in which treatment is obtained.

Diagnostic Accuracy in Obsessional Harassment Evaluations

Several overarching principles should guide mental health assessment of a potential or confirmed obsessional harassment offender. Because an accurate diagnosis of the clinical basis for obsessional harassment is necessary before treatment recommendations can be made, a thorough clinical evaluation of any offender referred for treatment is necessary. Unfortunately, many obsessional harassment offenders (particularly those with delusional disorders or personality disorders) minimize the extent of their harassment and rationalize their behaviors [e.g., (Meloy, 1998)]. While the diagnostic typology described above may be helpful in guiding the evaluation process (by anticipating the types of symptoms or disorders that may be present depending on the nature of the harassment), a definitive diagnosis requires a thorough assessment of the symptoms and behaviors of the offender. Many offenders, however, deny psychiatric symptoms or minimize problematic behaviors. Thus, obtaining third party information regarding the behaviors and actions of these offenders is often crucial to accurate assessment. Although forensic evaluators are typically aware of the importance in obtaining third party information regarding the behavior of evaluatees, this practice is relatively uncommon among treating clinicians. Nevertheless, without such sources of information, one may be unable to accurately differentiate among delusional, personality disordered or other types of obsessional harassment offenders.

A second issue in the assessment of obsessional harassment offenders concerns the accuracy of the label “obsessional harassment.” Although accurate statistics are not available as to what percentage of alleged “stalkers” are inaccurately labeled (i.e., falsely accused or mistakenly characterized as obsessional harassment offenders), this percentage is certainly not zero. That is, not all individuals accused of obsessional harassment have in fact engaged in this behavior. Some of this erroneous characterization is likely due to the increasing public attention focused on obsessional harassment, as many individuals who would have once been considered over-zealous ex-boyfriends or spouses are now labeled “stalkers.” Other individuals may accuse someone of obsessional harassment because of their own distorted perception of reality, a phenomenon termed “false victimization syndrome” (Mohandie, Hatcher, & Raymond, 1998). No doubt these inaccurate characterizations represent only a small fraction of obsessional harassment cases that are reported to the authorities, however, the potential for false allegations may increase depending on the situation. For example, when either or both parties are engaged in
civil litigation or family court proceedings (e.g., custody, divorce), the potential for false accusations is likely increased.

Similarly, whenever one considers a diagnosis of delusional disorder, it is likely prudent to first establish whether any basis for the beliefs exist. One may be tempted to presume seemingly unrealistic paranoid beliefs are delusional when a factual basis for the offender’s anger actually exists. This distinction may reflect a difference between psychotic, paranoid individuals, and those with a personality disorder, and obviously has significant implications for treatment. Only with an understanding of the context for the alleged offender’s behavior can the evaluator establish whether or not the behavior in question was appropriate or inappropriate, and therefore, whether or not mental health treatment is even warranted.

**Countertransference Issues**

Mental health clinicians who find themselves with an obsessional harassment offender as a patient may have both appropriate and unwarranted fears regarding their ability to evaluate and treat these individuals. The impact of countertransference will, of course, vary across individual clinicians, but may nevertheless impact negatively on the treatment process [e.g., (Madden, 1987; Maier & Van Rybroek, 1995)]. Whenever clinicians treat potentially dangerous individuals, the tendency exists to deviate from normal therapeutic procedures although such deviations are not innately negative. In institutional settings, for example, clinicians may wish to conduct therapy sessions with a potentially dangerous offender in public view or with security personnel nearby. While this practice may have some negative repercussions on the speed with which one develops a therapeutic relationship, the increased comfort level for therapist (and possibly for patients as well) often outweighs any disadvantage.

In outpatient settings, however, these issues become more complex. For example, in an outpatient psychotherapy clinic, clinicians may be prone to ignore topics that are important because of a fear that the patient/offender will become angry. Avoidance of potentially significant topics out of therapist fear is likely to significantly hinder any progress towards resolving these issues. If adequate comfort and safety cannot be established, therapists may wish to transfer the patient to another therapist or seek outside supervision in dealing with their countertransference reactions. In addition, where the potential (or fear) exists that an obsessional harassment offender may become fixated on the therapist, therapists may seek to maintain an emotional distance from the patient, essentially attempting to prevent a bond from forming. Although this strategy is unlikely to be effective in preventing an obsessional fixation (since fixations occur when no bond or even contact has been established, and there is little evidence that greater intimacy or proximity corresponds to a higher likelihood of being harassed), it may hinder the treatment process substantially (e.g., by limiting the therapist/patient bond and impeding the development of a trusting alliance).

Of course, therapist fears are not necessarily unwarranted, as many obsessional harassment offenders change the target of their obsession several times or more and an obsessive fixation on one’s therapist is not rare (Lion & Herschler, 1998; Romans, Hays, & White, 1996). Thus, awareness of the potential for such a fixation should guide decisions as to what gender, race, age, etc. is most appropriate for the therapist of an obsessional harassment offender. For example, knowledge that a particular offender has always fixated on older Caucasian males should suggest that a young female therapist may be more appropriate for this offender. Since many obsessional harassment offenders follow some pattern in their selection of targets, this information should be readily available to any treatment providers working with these offenders.
Assessing Treatment Compliance/Outcome

Another critical issue in the treatment of obsessional harassment offenders concerns the assessment of treatment compliance and outcome. How does one determine when a symptom has been resolved, particularly if that symptom is a delusional belief? Reliance on patient self-report is obviously problematic given both the frequent denial of any pathological behavior coupled with the obvious incentive to appear psychologically healthy. Thus, third party information may be necessary to determine treatment response. For example, blood testing for medication levels may be helpful in establishing whether or not a delusional or psychotic patient has in fact been compliant with prescribed medications. Contact with family members or friends may also be necessary to determine the extent to which problematic behaviors or attitudes persist outside of the therapy setting, as many patients may develop the capacity to refrain from discussing their delusional beliefs without actually giving up these beliefs. Finally, periodic contact with the target(s) of harassment may be necessary to insure that harassment has indeed stopped when the patient claims it has.

Obtaining Treatment for Obsessional Harassment Offenders

One of the most significant problems in securing treatment for obsessional harassment offenders is the reluctance of most offenders to voluntarily comply with treatment recommendations. Fortunately, a growing number of mechanisms exist for obtaining treatment even when the patient is unwilling. Several of these options, including those provided by civil statutes as well as criminal law, are reviewed below. In general, most forms of mandatory treatment require evidence of dangerous or threatening behavior. Thus, not only must the harassment have escalated to the point where some significant risk of harm exists, but evidence of this risk must be available to the trier of fact in any proceeding in which the goal is mandatory treatment. This requirement, of course, represents a significant stumbling block for many victims of obsessional harassment, as much of the harassment, while disturbing, is not necessarily overtly dangerous (Tjaden & Thoennes, 1998).

Criminal Law Options

In the past decade, all 50 states have passed legislation aimed specifically at stalking or obsessional harassment. Many of these statutes include provisions for obtaining mental health treatment during incarceration and/or as a condition of sentencing. For example, California modified its penal code to facilitate the treatment (even including transfer to a psychiatric facility, if warranted) of individuals convicted of stalking (Fritz, 1995). Since obsessional harassment is a misdemeanor in many states (at least for first offenses) and lengthy periods of incarceration are unlikely, ordering treatment as a condition of probation, which may last several years, is often a more effective long-term solution to ensure that these offenders are treated adequately. More significantly, however, the ability of courts to require medication compliance rather than merely ordering mental health contact is less clear and may represent an unreasonable infringement on the liberty interests of the defendant. This option, of course, was available to judges long before any formal provisions were offered under anti-stalking laws. Unfortunately, noncompliance with treatment ordered as a condition of probation is common even when offenders face possible jail sentences for failing to comply. Careful monitoring by probation or parole officers and/or the prosecutor’s office is likely necessary to ensure treatment compliance.
and these authorities must respond quickly to reports of non-compliance in order for the threat of sanctions to be meaningful.

Although other mechanisms exist within the criminal law for obtaining necessary treatment for mentally disordered individuals charged with criminal offenses, these alternatives are often more difficult to access by victims, prosecutors, or even judges. For example, criminal defendants who are found incompetent to stand trial are typically ordered into psychiatric treatment that includes involuntary medication if warranted. Since many individuals who engage in obsessional harassment are diagnosed with major mental disorders, a percentage of these offenders are likely incompetent to stand trial. This mechanism for obtaining treatment, however, has several significant limitations for the successful treatment of obsessional harassment offenders. First, the focus of treatment for trial incompetence is restoration of competence, not symptom resolution. Thus, defendants who return to prison after having been restored to competence may subsequently refuse medications or therapy, yet still be competent to stand trial. Moreover, in some jurisdictions (e.g., New York State), misdemeanor charges of harassment are automatically dismissed upon a finding of incompetence. Therefore, no mechanism may exist within the criminal justice system for obtaining outpatient or long-term treatment of these offenders once psychiatric hospitalization is no longer necessary.

Civil Law Options

Two mechanisms exist within the civil laws of most states for obtaining mandatory treatment of individuals who otherwise refuse treatment: involuntary hospitalization and outpatient commitment. Involuntary hospitalization of an individual due to mental disorder is permitted in every state, although the requirements are defined somewhat differently by each state’s statutes (Brakel, 1985). Despite jurisdictional differences, the core criteria for involuntary hospitalization are essentially the same across all states. Only those mentally disordered individuals who are determined to be dangerous to themselves or others, or grossly unable to care for themselves, are eligible for involuntary hospitalization. Thus, in order to apply civil statutes for involuntary hospitalization to obsessional harassment offenders, one must typically prove that a significant danger of harm exists unless hospitalization occurs.

Proving dangerousness in a legal proceeding (since individuals involved in commitment hearings are guaranteed many of the rights that apply to criminal defendants) is often a challenging task. Careful documentation of any threats or attempts to initiate contact that have occurred is therefore necessary before any petition for involuntary hospitalization can occur. However, if evidence of dangerousness exists, the victims of obsessional harassment may be able to file for the involuntary hospitalization of their harasser. A successful application for commitment, of course, merely guarantees that the offender will be hospitalized, not necessarily that he or she will receive psychotropic medications or even psychotherapy to address their problematic behaviors or symptoms. More importantly, the term of commitment ends when the offender no longer appears to present a danger

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3 Although initial harassment charges constitute a misdemeanor offense in New York State, subsequent charges may be indicted as felonies. Misdemeanor defendants found incompetent to stand trial, however, have their charges automatically dismissed. Thus, defendants repeatedly found incompetent to stand trial essentially have a revolving door of arrests, brief psychiatric hospitalizations after findings of incompetence, release and re-arrest.

4 Precisely who may file an application for involuntary hospitalization also varies across jurisdictions. See Brakel (1985) for a review of legislation regarding this process.
to self or others, an endpoint that may arrive well before sufficient improvement in symptoms or obsessive preoccupations have occurred. Evidence of continued harassment or fixation during involuntary hospitalization is likely to be compelling evidence for a judge considering release or further retention of the offender, but the potential for premature release certainly exists.

Another alternative that may be a potentially useful mechanism for obtaining treatment of obsessional harassment offenders is outpatient commitment. Outpatient commitment, in which patients are essentially committed to a period of outpatient treatment, has become an increasingly popular and effective alternative to traditional involuntary hospitalization. This alternative, which applies many of the same legal proceedings used for involuntary hospitalization to mandatory outpatient treatment, arose in the 1980s as a means of overcoming the shortcomings of involuntary hospitalization (Slobogin, 1994; Torrey & Kaplan, 1995). While all states have some legislation permitting outpatient commitment, the frequency with which this alternative is used varies considerably (Torrey & Kaplan, 1995). Nevertheless, the possibility that long-term treatment can be ordered, along with the ability to respond rapidly to treatment noncompliance, has the potential to be a useful vehicle for obtaining treatment for obsessional harassment offenders. In addition, several states require a substantially lower threshold for outpatient commitment than for involuntary hospitalization, resulting in a greater ability to commit individuals who might not otherwise meet the criteria for involuntary hospitalization. Unfortunately, while preliminary data suggest that the use of outpatient commitment leads to a decreased rate of rehospitalization, little research has demonstrated improvements in symptom severity, medication compliance, or decreased likelihood of future violent behavior [see (Swanson et al., 1997), for a discussion of limitations in this research literature]. Nevertheless, the potential utility of these mechanisms to obtain treatment for obsessional harassment offenders is considerable, albeit relatively untested.

CONCLUSIONS

Although potential treatments may exist for many of the mental disorders that underlie obsessional harassment, the difficulties in establishing treatment and maintaining compliance should not be underestimated. Such difficulties are well-known to the families of chronic psychiatric patients who have complained for decades about the systemic barriers to securing treatment for their family members who are unwilling to seek treatment voluntarily. Similar problems no doubt exist in attempting to utilize existing legal mechanisms to obtain treatment for obsessional harassment offenders who are likely to refuse any such recommendations.

Rather than frustrate those individuals who would seek treatment for obsessional harassment offenders, the presence of systemic obstacles to obtaining potentially helpful treatment will hopefully incite advocates and victims to demand systemic changes. Public pressure on local prosecutors and probation departments, which have typically been reluctant to aggressively monitor obsessional harassment offenders (unless those offenders happen to target wealthy or famous individuals), may result in a greater willingness to devote resources to the development of specialized programs or units for dealing with obsessional harassment offenders. With the provision of specific individuals assigned to monitor the behavior and treatment compliance of obsessional harassment offenders, the likelihood of successful intervention is considerably improved. Without such monitoring, however, it will not be possible to accurately assess the relative effectiveness of various psychological, pharmacological, and criminological interventions.
Unfortunately, most of the existing and proposed mechanisms for obtaining treatment for obsessional harassment offenders require that several factors be demonstrated including the presence of the harassment and the potential for, or existence of dangerous behavior. As such, documentation of all harassment is essential. Retaining answering machine recordings, mail and names and addresses of witnesses to any public incidents are all beneficial if one’s attempt to resolve harassment results in legal proceedings. Although some recent state statutes have defined threat and harassment sufficiently loosely to enable prosecution based on the victim’s perception of a threat rather than overt evidence of dangerous behavior, most states continue to require proof of both harassment as well as potential danger (Flynn, 1993).

Victims of obsessional harassment have long been skeptical as to whether any successful interventions, legal or mental health, can successfully stop this behavior. The research reviewed here is not likely to alter this skepticism significantly as no treatments for obsessional harassment have been either proposed or systematically studied. However, many of the suggestions and conclusions drawn from this review should foster guarded optimism that effective treatments may exist along with several mechanisms for obtaining treatment for obsessional harassment offenders. Once meaningful attempts at treating these individuals have occurred, researchers can begin to ascertain which, if any interventions have the greatest efficacy for particularly types of offenders. Only with continued public and professional pressure on legislative bodies, law enforcement and correctional personnel, and prosecutors will the systemic changes occur that are necessary before meaningful interventions for obsessional harassment begin.

REFERENCES


Obsessional Harassment


