Abstract

The present paper illustrates the use of the *Guidelines for Stalking Assessment and Management* (SAM; Kropp, Hart, & Lyon, 2008) to assess violence risk and recommend management strategies in a case of stalking. Through this case analysis we will also highlight and try to better understand the phenomenon of stalking of mental health professionals by their clients. The case study under examination involves a perpetrator who, over the course of multiple decades, stalked four mental health professionals whom she had sought out and seen for therapy. The SAM is a violence risk assessment instrument for stalking. Designed in the structured professional judgment framework, the SAM contains six steps. The SAM was completed by two individuals trained in its use and in violence risk assessment generally and reviewed by one of the authors of the SAM. The results present the analysis of each of the six steps, identifying key risk factors and motivations for the stalking behavior and recommending management strategies to end the stalking behavior. The discussion highlights research needed to compare available methods for assessing risk in stalking cases and describes wider applications for the findings with respect to the stalking of mental health professionals.

*Keywords*: Stalking; violence risk assessment; violence risk management; SAM; mental health professional; stalking motivation

Serial Stalking of Mental Health Professionals: Case Presentation, Analysis and Formulation Using the *Guidelines for Stalking Assessment and Management* (SAM)

Stalking, or criminal harassment, as it is known in the *Canadian Criminal Code* (s. 264(1), 1985), may be defined as the “unwanted and repeated communication, contact, or other conduct that deliberately or recklessly causes people to experience reasonable fear or concern for their safety or the safety of others known to them” (Kropp, Hart, & Lyon, 2008, p. 1). Although criminalized relatively recently and only in some countries, stalking is a global issue that has severe physical, psychological and economic consequences for victims (Brown, Dubin, Lion, & Garry, 1996; Galeazzi, Elkins, & Curci, 2005; Gentile, Asamen, Harmell, & Weathers, 2002; Leavitt, Presskreischer, Maykuth*,* & Grisso, 2006; Purcell, Powell, & Mullen, 2005). Prevalence estimates range from 4% to 7% for women and are around 2% for men (Basile, Swahn, Chen, & Saltzman, 2006; Canadian Centre for Justice Statistics, 2005). Prevalence estimates are considerably higher however, for individuals holding certain professions.

One such professional group is mental health professionals (psychologists, psychiatrists, counsellors, etc.) (for reviews, see Galeazzi & De Fazio, 2006; Mullen, Pathé, & Purcell, 2009, Storey, 2012). Nearly a third of counselors, 11% of psychiatrists, and 19.5% of psychologists report being stalked in the context of their professional lives (Lion & Herschler, 1998; Smoyak, 2003; Whyte, Penny, Christopherson, Reiss, & Petch, 2011). Moreover, 32% to 64% of counselors have been the victim of some form of harassing behavior from a client (Romans, Hays, & White, 1996; Storey, 2016). Research on this phenomenon is growing with important work being conducted with the aim of managing the problem (e.g., Carr, Goranson, & Drummond, 2014; Regehr & Glancy, 2011). Despite recent work in the area, the specific reason that mental health professionals are at heightened risk of being stalked has not been empirically determined. Several hypotheses have been forwarded and they include increased contact with mentally ill or offender populations, the empathetic and accepting relationship that mental health professionals develop with clients that can be misinterpreted by clients who have limited social skills as more than professional, and the adversarial contexts in which mental health professionals work (e.g., providing assessments for child custody or criminal cases) (Galeazzi & De Fazio, 2006; Kropp et al., 2008; Kropp, Hart, & Lyon, 2002; Meloy & Boyd, 2003; Purcell, Pathé, & Mullen, 2001; Purcell et al., 2005).

Although not completely understood, identifying the motivation for stalking behavior is vital when attempting to assess and manage stalking risk. To assist in identifying motivation and assessing and managing stalking risk, two risk assessment instruments for stalking have been developed: the *Guidelines for Stalking Assessment and Management* (SAM; Kropp et al., 2008) and the *Stalking Risk Profile* (SRP; MacKenzie et al., 2009). Perhaps owing to the complexity and heterogeneity of stalking, no other structured approaches to stalking risk assessment currently exist. The SAM and the SRP share a similar structure since they both follow the structured professional judgment (SPJ) approach to violence risk assessment. The SPJ approach refers to the process through which information is gathered and analyzed. In the SPJ approach, guidelines, created based on a systematic review of the empirical, professional, and legal literatures, are employed by evaluators to guide their assessments. SPJ instruments outline the minimum criteria that should be considered as part of a comprehensive assessment, but also allow evaluators to consider additional case specific risk and protective factors. In addition, SPJ instruments provide recommendations regarding the type of information that should be considered, how to develop management plans, and how to communicate the results of an assessment. The SAM and the SRP also converge on the idea that an evaluator must understand the motivation behind the stalking behavior to properly assess and manage a case. Violence risk assessment in cases of stalking is important and can be of great benefit because stalking is repeated and targeted, meaning that we know the behavior will likely continue and we know who the victim will be. As a result of the patterned behavior, we can, with the aid of empirically derived instruments, assess the likelihood of continued stalking, including its nature, severity, imminence and frequency/duration and determine how to prevent the stalking behavior through monitoring, supervising or treating the perpetrator and protecting the victim.

**Current Study**

The present paper seeks to achieve three nested goals. The first goal is to demonstrate how to use a violence risk assessment instrument to assess and manage stalking risk. The second, is to illustrate how, through the assessment process, we can better understand the motivation and dynamics of stalking. Third, through uncovering the motivation and dynamics of the case we hope to shed some light on the phenomenon of stalking of mental health professionals. The study therefore seeks to illustrate some of the work that has already been conducted in the area of stalking risk generally by presenting a case analysis focused on a specific sub-group of stalkers who pursue those that provide care.

To achieve the goals, a case study involving a perpetrator who stalked four of her female therapists will be assessed and discussed. The SAM will be used to complete the violence risk assessment herein. The case study was selected because it is a case of serial stalking, meaning that the perpetrator engaged in multiple stalking incidents with multiple victims over a distinct period of time (Llyod-Goldstien, 2000; Pethrerick, 2009). The advantage of using serial cases is that they provide a clearer picture of the perpetrator. Owing to the repeated pattern of the perpetrator’s actions across time, situations, and victims, we can identify behaviors and characteristics unique to the perpetrator as opposed to those influenced by a specific set of circumstances. Separating the perpetrator from the specific set of circumstances surrounding them in a given case can help to clarify the dynamics of the stalking and the motivation of the perpetrator. For instance, if a pattern such as the type of victim selected is present across multiple cases we can eliminate the possibility that the stalking was motivated by a unique relationship or exchange between the perpetrator and the victim and instead consider that the type of victim may be central to the perpetrator’s motivation. As will be seen in the present case, the perpetrator repeatedly seeks out the same type of victim for the same reasons, and this pattern reflects her internal motivations for engaging in stalking.

For the sake of continuity and brevity, those who engage in stalking behavior will be referred to as *perpetrators* and those who are the targets of stalking behavior will be referred to as *victims*. In lieu of research questions, findings of note related to stalking risk assessment, motivations for stalking, and the pursuit of mental health professionals will be outlined in the discussion.

**Method**

**Overview**

A violence risk assessment was conducted, using the SAM, for a case study involving a single perpetrator who stalked four victims over the course of multiple decades. The analysis of the case demonstrates the use of the SAM in assessing violence risk and identifying the perpetrator’s motivation for stalking her victims, all of whom were mental health professionals. Ethical guidelines were followed in completing the study and reporting the case details.

**Case Summary**

The case study presented herein (see Appendix) is a summary of four stalking incidents committed by a single perpetrator, Meghan, that occurred over approximately two decades. As the case includes multiple victims and spans many years, a timeline is presented to facilitate comprehension (see Table 1). The case summary is based on case records obtained from a company hired to evaluate the perpetrator following the most recent stalking behavior. The company employed to conduct the evaluation was hired following the perpetrator’s arrest and conviction for criminal harassment (i.e., stalking) against Dr. Smith and tasked to assess the perpetrator’s risk for violence and continued stalking for the purposes of sentencing. For the present case analysis, the stalking behavior toward Dr. Smith will serve as the critical event, and the three prior incidents of stalking will be considered under past stalking behavior.

The research procedures used received ethical approval from the appropriate institution and agency. In compliance with the recommendations of the American Psychological Association (2010) and to protect the anonymity of those involved, names, dates, and locations have been changed. In addition, details of the case not essential to the outcome of the case analysis have been altered.

**Case Analysis and Formulation**

The case analysis was completed by JES and YLL based on the case summary. The case analysis was reviewed by SDH and disagreements were resolved via discussion and a review of case information. Two of the evaluators have PhDs in psychology and one has a Masters in psychology. JES and YLL are trained in the use of the SAM, and SDH is a co-author of the SAM.

**The Stalking Assessment and Management guide (SAM).** The SAM (Kropp et al., 2008) is a SPJ tool designed to assist evaluators in the assessment and management of stalking (as defined above). Complete details regarding the administration of the SAM can be found in the user guide. The SAM is flexible in nature and can be used in different ways by different types of professionals to assess and manage the risk of stalking.

The SPJ risk assessment process used in the SAM is accomplished through six steps. Step 1 is to gather and summarize all relevant case information. Step 2 is to consider the presence of the 30 SAM risk factors both currently (during the current stalking episode) and in the past (during past instances of stalking). Herein we considered the stalking of Dr. Smith to be the current stalking episode and we provided three past ratings, one for each victim. Risk factors in the SAM and other SPJ instruments are scored on a 3-point scale *Present, Possibly or partially present,* or *Absent*. The risk factors in the SAM are divided into three domains. The *Nature of Stalking* domain includes 10 factors related to the stalking behavior being perpetrated. The *Perpetrator Risk Factors* domain includes 10 factors related to the perpetrator’s psychosocial adjustment and background. The *Victim Vulnerability Factors* domain is comprised of 10 risk factors related to the victim’s psychosocial adjustment and background. Evaluators can also consider rare, unusual, or case-specific risk factors. The SAM items and domains are included in Table 2. In Step 3, evaluators indicate the relevance of the risk factors to future violence perpetration and violence risk management. Relevance is coded using the same scale used to code the presence of the risk factors. In step 4, evaluators identify the most plausible scenarios of future stalking or violence in the case under evaluation. Step 5 includes the formulation of management strategies that are designed to mitigate the identified risk factors and scenarios. In Step 6, six conclusory opinions regarding overall risk are made by the evaluator based on the risk factors identified as present in the case.

**Formulation**. In the SPJ approach formulation comprises two tasks. In the first task, the evaluator must formulate an account or explanation for the perpetrator’s past violent behavior and explain why as a result they might continue to pose a risk for violence in the future. In the second task, the evaluator formulates plans to mitigate the risk. The first task is included in Step 3 of the SAM where the evaluator identifies the relevance of risk factors. Task number two is included in both Steps 4 and 5 wherein the evaluator formulates management plans.

In the present paper, we developed a formulation of Meghan’s stalking based on the SAM analysis following the instructions outlined in the manual. Specifically, we developed a formulation based on a Decision Theory or Action Theory framework. Decision Theory posits that violence is a form of purposive human action. It is the result of choice, a decision-making process that starts with having a certain goal or desire—even if inchoate and ephemeral—and then moving to intent and finally to action. Under this framework, people are assumed to have agency and to make rational choices about the use of violence—although rational only in the limited sense of involving thought, and not rational as in logical or correct or appropriate. Indeed, choices can be bad or poor (e.g., those with non-optimal or maladaptive outcomes) or be made badly or poorly (e.g., in disorganized, impulsive, or incoherent manner) due to a multitude of factors that impinge on this process. The goal of case formulation in risk assessment then is to understand how risk factors might motivate, disinhibit, or destabilize decisions about violence in particular cases.

Since its development in 2008, five published studies have reported on the psychometric properties of the SAM. The SAM has generally shown moderate to good interrater reliability (Foellmi, Rosenfeld, & Galietta, 2016; Kropp, Hart, Lyon, & Storey, 2011; Storey & Hart, 2011; Storey, Hart, Meloy, & Reavis, 2009), concurrent validity with measures used to assess general violence risk (Kropp et al., 2011; Storey et al., 2009), structural reliability (Foellmi et al., 2016; Kropp et al., 2011), and both validity and utility when used in practice (Belfrage & Strand, 2008). The only study to examine the predictive validity of the SAM found that when time at risk was considered, SAM total scores, Nature of stalking and Perpetrator risk factor domains predicted stalking but not violent recidivism, and that overall risk ratings were not predictive of recidivism (Foellmi et al., 2016). It is important to note that Victim vulnerability factors were not examined as part of the study.

**Results**

Here we present a case analysis and formulation using the SAM at the time that Meghan was sentenced for the criminal harassment of Dr. Smith (September 2012). The purpose of the case analysis and formulation is to assess the risk that Meghan poses to Dr. Smith and make recommendations to the court regarding sentencing, with the aim of stopping Meghan’s behavior and protecting current and potential future victims. The case analysis described herein is representative of what specialists in violence risk assessment would complete; it is an in-depth case analysis and formulation that is also somewhat treatment oriented. Evaluators with different professional backgrounds may require a less in-depth analysis or one that focuses on different forms of management (e.g., victim safety planning).

**Step 1: Case Information**

The SAM was completed based on the information in the case summary. Although limited in some areas (e.g., Meghan’s childhood and personal relationships) it represents what was available to threat assessors and is similar to that typically available. In addition, we believe the information was sufficient to reach the findings and opinions expressed herein with a reasonable degree of confidence and certainty.

The perpetrator in the present case is Meghan Stanley and the current victim, whom Meghan has been stalking since 2009, is Dr. Laurel Smith. Meghan’s previous victims, whom she pursued for varying lengths of time between 1992 and 2009, include Dr. Rebecca Walters, Dr. Tamara McGee, and Dr. Emma Betts.

The sources of information used to complete this evaluation include police reports of the stalking incidents, an interview conducted by a psychologist with Meghan during her pursuit of Dr. Betts, emails written by Meghan to Dr. Smith, a psychiatric report completed about Meghan, and victim impact statements from Dr. McGee, Dr. Betts, and Dr. Smith.

The gist of Meghan’s stalking behavior is that both her past and present episodes of stalking have targeted female psychologists whom she sought out for treatment. The behaviors in each episode of stalking showed several similarities. They typically began with excessive and unwanted communication and boundary violations to increase her contact with the victims, in combination with information gathering and sexual infatuation with the victims. This was often followed by her refusal to end therapy sessions, confinement of the victims in their offices, and encounters outside of session. These actions generally prompted attempts at therapeutic termination by the victims that sometimes caused Meghan’s behavior to escalate to veiled threats, violence toward herself, and minimal physical aggression toward her victims.

**Step 2: Presence of Factors**

Risk factor presence ratings for each of the four stalking episodes are presented in Table 2. Across the four episodes of stalking, risk factors were present in all three SAM domains, with both the Nature of stalking and Perpetrator risk factors containing primarily present and possibly or partially present risk factors and the Victim vulnerability factors being primarily absent.

**Pattern of stalking 1: Dr. Walters.** With respect to the Nature of stalking domain, the case information included evidenced that seven of 10 risk factors were present or possibly/partially present. The nature of the stalking experienced by Dr. Walters was in many ways similar to that experienced by the three victims who came after her. Meghan engaged in boundary violations which included communication with, approaching, and direct contact with Dr. Walters. In addition, Dr. Walters and one of Meghan’s other victims experienced violence, and she and two of the other victims experienced stalking that was persistent and escalating. Where Dr. Walters’ experience differed was that Meghan, to our knowledge, did not communicate about Dr. Walters to others and Meghan’s pursuit of Dr. Walters continued for a greater length of time.

The case information yielded evidence that seven of 10 perpetrator risk factors were present, at least to some extent. During this first episode of stalking Meghan displayed anger when her relationship with Dr. Walters began to deteriorate. The length and frequency of her pursuit demonstrated her obsession with Dr. Walters. Meghan displayed unrepentant behavior when she continued her pursuit despite clear signs that Dr. Walters was upset and wanted her behavior to cease. For instance, Meghan ignored contracts and letters that outlined behaviors that needed to cease and she forcefully kept Dr. Walters in her office on two occasions for multiple hours and physically tried to take her keys. Meghan’s intimate relationship problems were evidenced by her sexual and romantic feelings towards Dr. Walters and the inappropriate behavior she engaged in to increase and maintain contact with Dr. Walters. Non-intimate relationship problems were evidenced by Meghan’s inability to maintain a positive non-conflictual therapeutic relationship. Some evidence of distress was apparent when Meghan stated that she had nothing to lose if therapy was over. It is difficult to determine whether this statement was a genuine reflection of Meghan’s distress or an attempt to manipulate or intimidate Dr. Walters into helping her continue her relationship with Dr. McGee. The assessment of Meghan’s level of distress was further hampered since limited information was available regarding Meghan’s ability to cope with life problems. Further, it was unclear whether she had feelings of anxiety or depression because the issues she discussed in therapy were fabricated.

One additional risk factor, Unresolved issues with sexuality, was considered under Perpetrator risk factors. It was hypothesized that Meghan might lack clarity regarding her own sexuality, possibly due to lingering issues resulting from an influential early relationship with an older female, and that this might be related to her current pursuit of women.

With respect to victim vulnerability factors, the case information included evidence that three of 10 factors were present to some degree. Dr. Walters displayed inconsistent behavior toward Meghan when she continued to treat her despite Meghan’s many boundary violations. Inconsistent attitudes were possibly evidenced by Dr. Walters’ promise to see Meghan again after being trapped in her office. Although this promise was made under duress, Dr. Walters did consult with others before ultimately deciding not to see Meghan, indicating some level of ambivalence and possibly some mixed attitudes toward Meghan. Dr. Walters’ decision not to call police may also reflect such mixed attitudes. It is however difficult to infer inconsistent attitudes without talking directly to the victim. Finally, concerns regarding Dr. Walters’ living situation included that Meghan had successfully entered Dr. Walters’ office without an appointment and held her there against her will and that Meghan, for a time, knew where Dr. Walters’ lived and beset her home.

**Pattern of stalking 2: Dr. McGee.** The nature of the stalking perpetrated against Dr. McGee included the presence of five of 10 Nature of stalking risk factors and was of a less severe nature than that perpetrated against the other victims since it did not include intimidation, violence, or supervision violations and was not persistent in nature. The pursuit did include communication with, approach behavior, and direct contact as well as the first identified instance of communication about the victim. Meghan spoke to her friend about Dr. McGee, complained to the college of psychologists about Dr. McGee and sought the assistance of Dr. Walters when Dr. McGee obtained a peace bond against her.

Meghan presented with most of the same Perpetrator risk factors (seven of 10) as in the previous episode of stalking; this is to be expected as the two instances of stalking overlapped temporally. For instance, the comment Meghan made to Dr. Walters about having nothing to lose if therapy were over was likely made in reference to Dr. McGee’s termination of therapy and receipt of a peace bond. One difference is that although problems with intimate relationships were present, they were in reference to Dr. Walters as Meghan did not express sexual feelings toward Dr. McGee. Thus, given her continued problems with intimate relationships the item was coded as present. It is highly likely that Meghan held intimate feelings for Dr. McGee based on the similarities across stalking episodes; however, an interview would be required to confirm this suspicion. Non-intimate relationship problems were again evidenced by Meghan’s inability to maintain a positive non-conflictual therapeutic relationship.

Partial evidence existed for only one of 10 Victim vulnerability factors. Dr. McGee was dissimilar to other victims in that she did not demonstrate inconsistencies in her behavior or attitudes toward Meghan. Dr. McGee did not offer Meghan a contract or other opportunities to change her behavior before deciding to terminate therapy, cut off contact, warn her colleagues, and involve police. She also did not place any limitations on the actions police could take to stop Meghan’s behavior. The possible unsafe living situation indicated in the SAM coding refers to the fact that Meghan knew where Dr. McGee lived, had managed to enter her apartment building and bang on her front door, and had been telling tenants in the building that she was a friend of Dr. McGee’s, which might assist her in gaining entrance to the building in future.

**Pattern of stalking 3: Dr. Betts.** The stalking behavior perpetrated against Dr. Betts was more severe than in the previous episode but slightly less severe than that experienced by Drs. Walters and Smith. There was evidence that eight of 10 Nature of stalking risk factors were present to some extent. Meghan engaged in similar boundary violations that escalated to more serious stalking behavior including barricading Dr. Betts in her office, causing her to feel frightened and intimidated. However, Meghan did not escalate to violence. What was novel in the stalking episode against Dr. Betts, was that Meghan violated a supervision order by repeatedly ignoring police warnings to cease her stalking behavior toward Dr. Betts.

The perpetrator risk factors that were present were similar to those in previous stalking episodes (seven of 10); Meghan displayed anger, obsessive behavior, an inability to maintain an appropriate therapeutic relationship, and explicitly described feelings of sexual attraction toward Dr. Betts. Although present in the past, Meghan’s lack of remorse and minimization of her behavior were particularly well evidenced during her interview with a psychologist when she justified her continued stalking behavior by essentially blaming Dr. Betts. No evidence of distress arose even though Meghan was interviewed giving her the opportunity to disclose such feelings to a mental health professional. This may suggest that her previous comment about having nothing left to lose if therapy was terminated was designed to manipulate Dr. Walters.

Evidence indicated that three of 10 Victim vulnerability factors were present at least to some degree. Dr. Betts evidenced inconsistent behavior and possibly inconsistent attitudes regarding Meghan. Meghan described Dr. Betts’ inconsistent behavior during her interview, citing several behaviors including that Dr. Betts would accept her calls, extend sessions, and told her that they could talk six months after therapeutic termination. In addition, Dr. Betts promised Meghan another session after Meghan held her in her office, although the promise was made under duress. It is posited that Dr. Betts might hold inconsistent attitudes toward Meghan because she did not allow police to arrest Meghan for her stalking behavior or her breaches of repeated police warnings to cease her stalking behavior. If Meghan had been aware of this she may have interpreted it as Dr. Betts’ ambivalence about ending their contact. The determination that Dr. Betts possibly had an unsafe living situation was made based on three facts, two of which indicated increased risk and one that was protective. First, Meghan had been following Dr. Betts and this indicates that she might have known where Dr. Betts lived. Second, Meghan was able to barricade and keep Dr. Betts in her office after a therapy session. Third, office security procedures prevented Meghan from getting to see Dr. Betts when she did to have an appointment.

**Pattern of stalking 4: Dr. Smith.** Similar to the pursuit of Dr. Walters the nature of the stalking behavior toward Dr. Smith constitutes some of the more severe stalking behavior perpetrated by Meghan and included evidence of eight of 10 Nature of stalking risk factors. Meghan’s present stalking behavior is similar to that which she has perpetrated in the past, including boundary violations that escalate to more serious intrusions. Her behavior includes all the Nature of stalking factors except for threatens victim and supervision violations. With that said, the latter could not yet be present given that Meghan has not been sentenced. Meghan’s behavior was particularly serious as it involved violence, barricading Dr. Smith in her office on three occasions, and was persistent. In addition, her communication about Dr. Smith was far greater than in previous episodes and included many personas, communication with Dr. Smith’s family, and impersonating Dr. Smith. Along with other stalking behaviors, these consumed 5 to 6 hours of her time each day.

Meghan showed evidence of possessing the same perpetrator risk factors as in the past (eight of 10). In this instance, however, her distress was potentially displayed through self-harm when she hit herself in the head with a paper weight. Again, this behavior could be indicative of distress or may have simply been an attempt to manipulate Dr. Smith into continuing their therapeutic relationship. Meghan experienced problems with employment for the first time; she was unemployed for six months and employed only part-time otherwise. This limited employment may have provided her with more time to engage in stalking behavior. However, it was clear that she was spending a great deal of time engaging in stalking in the past and her previous employment status is unclear.

The case information included evidenced that three of 10 Victim vulnerability factors were present to at least some degree. Dr. Smith displayed inconsistent behavior, and by her own admission inconsistent attitudes toward Meghan. Dr. Smith continued to treat Meghan after Meghan had twice barricaded Dr. Smith in her office and had violated her ultimatum. It should be noted that Meghan used manipulation to continue therapy, playing on Dr. Smith’s instincts not to abandon a client in crisis. Dr. Smith admitted to minimizing Meghan’s behavior and to being conflicted due to feelings of professional obligation. These inconsistencies recently ended when Dr. Smith learned of Meghan’s fabrications in therapy and her past stalking behavior. Like Dr. Betts, the possible unsafe living situation refers to the possibility that Meghan knew where Dr. Smith lived and that she had successfully barricaded Dr. Smith in her office on three occasions but had been unsuccessful in entering Dr. Smith’s office without an appointment.

**Overall pattern of stalking.** The similarity in the presence of risk factors across all four instances of stalking is quite striking. Meghan showed a very clear stalking pattern, beginning with small intrusions such as communicating with her victims, escalating to more serious intrusions including approach behavior and where possible engaging in direct contact and intimidating behavior by barricading her victims in a room, and on two occasions engaging in violence toward them. It was also evident that Meghan continued to use strategies in future stalking campaigns that had worked for her in the past, such as barricading herself in an office to get another therapy session. She also increased her communication about her victims over time from none (that we know of) in the first stalking episode to 25 personas and several hours of her time each day in the fourth. This was a difference across stalking episodes that may have resulted from the personal satisfaction Meghan received from the increased contact and control she gained (e.g., hearing back from her victim more often, being able to trick her victim), the information she was able to attain, and developments in technology (e.g., email). Another difference that appeared across stalking episodes was in severity, in that episodes one and four (Dr. Walters and Dr. Smith) were more severe in nature than episode two (Dr. McGee). For instance, episodes one and four both involved violence and included almost all Nature of stalking risk factors; in addition, the first episode lasted significantly longer than the others. The second stalking episode was less severe, having fewer Nature of stalking risk factors, Dr. McGee was never barricaded in her office or assaulted, and the stalking behavior ended after a peace bond was implemented. One possible explanation for the reduced number of Nature of stalking factors was the rapid involvement of police in the second episode.

The perpetrator risk factors attributed to Meghan remained relatively stable across time, including the way they presented themselves. For instance, Meghan held positive and even romantic feelings for her victims at first, and later became angry when they limited her contact with them. She expressed her anger through messages, in person contact, and by making official complaints against two of her victims. Her obsessive nature was diagnosed as obssessional disorder and was also evidenced by the amount of time and effort she devoted to pursuing her victims. As previously mentioned, Meghan presented as unrepentant more obviously during some episodes of stalking than others. However, in all episodes Meghan clearly persisted in her behavior despite being asked to stop and clear signs that her victims were unhappy with her behavior. Her presentation as distressed vacillated across stalking campaigns. However, as previously noted this may have been because she was feigning distress to manipulate her victims. Anecdotal support for this hypothesis comes from the fact that Meghan fabricated a major life crisis to avoid therapeutic termination by Dr. Smith.

Similarities in the presence of victim vulnerability factors across the four victims were present but more difficult to confirm since victims were not directly asked about the factors. Because Dr. Smith provided a detailed statement her inconsistent attitudes were confirmed; for Dr. Walters’ and Dr. Betts’ attitudes were inferred from behavior. It is likely that inconsistent attitudes were present among these three victims as they were all victims of a crime perpetrated by their client and held the same professional ethics wherein they were bound to not abandon a client in need and to ensure the client’s successful transfer to another professional. Dr. McGee did not evidence these attitudes and behaviors, and this may have been due to her knowledge of Meghan’s behavior toward Dr. Walters. The other three victims did not find out about Meghan’s previous stalking behavior until much later in their respective stalking campaigns, or in the case of Dr. Walters there was no previous stalking campaign. Differences in the ratings of the safety of the victim’s living situations depended primarily on their office security and whether Meghan knew where they lived.

**Step 3: Relevance of Factors**

The relevance of the factors was rated based on the factors’ functional or causal relationship to the stalking behavior as well as their utility in developing risk management strategies. Risk factors causally related to stalking behavior can play one of three functional roles; they can motivate, disinhibit or destabilize the perpetrator.

One set of relevance ratings based on all four episodes of stalking were made. This was done for two reasons. First, based on the similarities across stalking episodes, Meghan’s past behavior is highly relevant to her future behavior and thus highlights where management should be focused. Second, the first three instances of stalking have been resolved and thus do not require management. Apart from N6 (*Threatens victim*) all the Nature of stalking risk factors were seen as relevant to risk management. The reasoning for this is that these risk factors indicate what Meghan has done (repeatedly) in the past and thus indicate what actions she might take in the near future with Dr. Smith or further into the future with another female therapist. Knowledge of likely future behavior can be used to decrease the possibility of future contact and increase victim safety. For example, changing phone numbers to decrease communication with the victim and increasing office security to decrease the likelihood of direct contact and intimidating or violent behavior.

All of the perpetrator risk factors that Meghan displayed across the stalking episodes were determined to be relevant as they indicate what might motivate future stalking behavior and where to focus treatment and supervision conditions (e.g., treatment for anger management, a prohibition from seeking out a female therapist). Inconsistent behavior and attitudes were coded as relevant for victims for two reasons. First, although with time each of the victims stopped behaving inconsistently toward Meghan this item is relevant because Dr. Smith will need to continue in this vein in order for Meghan’s stalking behavior to end. Second, and probably more important, is that should there be another victim these vulnerabilities will need to be addressed and hopefully eradicated early on. The actions taken by Dr. McGee indicate that early intervention might help to avoid escalation by Meghan and end her stalking behavior. The vulnerability factor Unsafe living situation was also found to be relevant because, where possible, Meghan will try to enter her therapists’ homes and offices uninvited. This factor indicates a need to increase security at the office and home of Dr. Smith, and to make such safety measures a priority for future victims.

Two facts about this case stood out to us. First was Meghan’s unresolved issues with sexuality, which was what brought her into therapy at the outset. We hypothesized this may be a key factor in her stalking and harassment of female therapists; neither of the male mental health professionals who treated Meghan reported being stalked or harassed. Indeed, Meghan reported being infatuated with the victims. More noteworthy was the fact that her choice of sexual targets were all women who were inappropriate and unavailable to her due to their professional relationships. There is no evidence to suggest Meghan has acted in a similarly inappropriate manner with other women in her life who may represent more viable romantic or sexual partners. It further appears Meghan intentionally sought out female therapists by fabricating issues to enter and continue therapy with the victims.

Secondly, Meghan’s behaviors were strikingly consistent across time, situations, and victims, suggesting her difficulties were likely more characterological than situational. Although it is not possible to diagnose Meghan without directly examining her, a working hypothesis of a personality disorder with borderline personality traits is offered here in light of Meghan’s previous diagnosis and her pattern of behaviors. Essential features of borderline personality disorder (BPD) include pervasive patterns of instability and dysregulation in interpersonal relationships, self-identity, emotions, behaviors, and cognition, beginning by early adulthood and continuing in a stable pattern over time and contexts (American Psychiatric Association, 2013). In particular, Meghan exhibited significant abandonment concerns, behavioral and cognitive impulsivity, and problems with anger. She also vacillated between apparent idealization and devaluation of her therapists, quickly developing sexual attraction to them and wanting more sessions with them then leaving angry voicemails and complaining about them to the college of psychologists. Unfortunately, we do not have sufficient information about Meghan’s familial history, childhood, and upbringing, especially around her early attachment styles, to speculate about the etiology for a possible personality disorder.

Overall, Meghan’s stalking appears to be primarily motivated by a desire for affiliation or proximity with the victims, that she achieved using two methods. Physically, Meghan would call her victims multiple times between sessions and fabricate crises to obtain extended or extra sessions. A more drastic demonstration of this was the forcible confinement of the victims and refusal to end therapy sessions. Meghan also beset locations where the victims were known to frequent, including their residences. Psychologically, Meghan attempted to feel closer to the victims by injecting herself into their social groups and gathering information about their private lives. A secondary motivator that may be at play here is status or esteem, in that Meghan continued to stalk and harass her victims to feel good about herself. Meghan revealed that she felt loved and cared for by Dr. Walters, and so she may be trying to extend and replicate these feelings through the stalking. That is, Meghan may have stalked and harassed her victims not only because she wanted to be close with them, but because she felt good about herself when she was close with them. Further, she may have gained some pleasure from feeling that she was able to control, dominate, and trick her victims. Another motivator that was present but less prominent was release and expression, especially of her anger toward the victims when they did not comply with her demands. Meghan’s decisions to engage in stalking were likely disinhibited by negative attitudes, such as beliefs that therapists are supposed to be available to her at all times; lack of empathy and insight into the wrongfulness of her behaviors and the distress she is causing her victims; and an overall lack of guilt and anxiety. Her problems with relationships and employment may have also created feelings of alienation that further disinhibited her. Finally, problems with perseverative and obsessional thinking and impulsivity appeared to have destabilized Meghan’s ability to make good decisions against stalking.

The motivators, disinhibitors, and destabilizers described highlight the primary risk factors in the case: angry, obsessed, unrepentant, and problems with intimate and non-intimate relationships. They can be further distilled and traced to a common root cause of an underlying mental health problem, likely a personality disorder, that has created problems for Meghan in terms of her relationships, emotions, self-image, and impulsivity.

**Step 4: Risk Scenarios**

Three scenarios were identified as being plausible scenarios of future stalking perpetrated by Meghan. The scenario that we identified as being the most plausible was for Meghan to repeat her previous behavior by seeking out a new female therapist and engaging in a similar pattern of stalking that would eventually escalate in the same fashion as in the four previous episodes. It is expected that this type of pursuit would last for a year or more, like it has in the past. Although it could be argued that this scenario is unlikely to unfold in the near future because Meghan’s pursuit of the four psychologists was spread across three decades, we must consider that we may not be aware of all of the stalking episodes perpetrated given that mental health professionals tend to underreport victimization. As such, we believe it is likely that Meghan will find and engage in stalking of a new female mental health professional in the near future. The likelihood of this scenario taking place is high because it reflects what Meghan has done after pursuing each of the previous three victims. There is a small possibility that Meghan may seek out the assistance of her previous victims in order to obtain a referral to a new female therapist.

The second scenario is a twist scenario wherein Meghan’s contact with the criminal justice system leads her to stalk a female social worker, police officer or probation officer. A trigger for this scenario would be the involvement of a female professional in her case who engaged with Meghan frequently or intensely. The likelihood of this scenario is lower than the first because to date Meghan has only pursued female therapists.

The third scenario considers how Meghan’s behavior might escalate and what might be the worst case scenario for continued offending. An escalation would likely involve a serious confrontation with a victim. We see two possible ways in which such an event could be triggered. First is a decline in Meghan’s mental health. Second is a scenario in which Meghan attends her victim’s home where children and weapons such as knives are present and where her victim feels highly threatened. Meghan has attended the homes of her victims in the past and a warning sign or red flag for this scenario would be if Meghan was able to locate and subsequently breach the security of the victim’s home. In such a situation, depending on the victim’s reaction to Meghan, Meghan may act out impulsively and potentially physically harm the victim and their family during the confrontation. The likelihood of this scenario is relatively low given that Meghan’s behavior has remained relatively consistent over the past four episodes of stalking.

**Step 5: Management strategies**

The management strategies outlined include those that could be imposed by the court, or used by victims, victims’ workplaces, and mental health professionals generally and are based on the risk factors and risk scenarios identified for the case. The management strategies for victims must be quite broad in this case because our scenarios of future violence include possible new victims who are as yet unknown and are of several professional types, as well as previous victims. The SAM outlines four activities to consider when identifying management strategies: monitoring, treatment, supervision, and victim safety planning.

Based on Meghan’s previous compliance with court imposed conditions we believe her risk to be manageable in the community. Monitoring of Meghan should include check-ins with her on a bi-monthly basis as well as less frequent check-ins with Dr. Smith. Monitoring of Meghan could be done by police, a court appointed supervisor (e.g., bail, probation) and/or a new therapist, but should always be done by a male. Meghan’s internet activity should be monitored in order to ensure that she is not communicating with or about any of her victims.

Treatment strategies should first include a comprehensive assessment conducted by a male mental health professional. Such an assessment is important so that future treatment can focus on Meghan’s needs and not be self-directed as it had been in the past. Based on the risk factors identified treatment should address at a minimum any mental health problems identified in the assessment, as well as her issues with relationships, sexuality, obsessive feelings, and anger. Most importantly, treatment should always be provided by a male mental health professional. If possible, Meghan’s court conditions should include a prohibition to seeking treatment from a female mental health professional and a requirement to disclose and provide the contact information of any mental health professional that she sees for treatment to her supervisor. Vocational training and/or assistance in finding work should also be provided since this will decrease the amount of time Meghan has available to engage in stalking.

Community supervision for Meghan should include conditions that prohibit her from having contact with Dr. Smith as well as any of Dr. Smith’s friends, family members, neighbors or co-workers. Conditions should also prohibit Meghan from attending Dr. Smith’s home and workplace. Meghan should be required to check-in with her supervisor and attend treatment. Meghan should only be allowed to use one email address and that address should be provided to her supervisor. Based on her history Meghan may apply to have her conditions lifted prior to their expiration; Meghan’s conditions should not be varied.

Victim safety planning for Dr. Smith could include such static security measures as changing her cell phone number, installing a panic button at work, installing a buzzer to allow people into the office, and having someone walk with her to her car after work. Perhaps most useful, however, would be to increase awareness of the issue and vigilance in her workplace and devise workplace safety procedures. For instance, such procedures could include showing a picture of Meghan to everyone in the office with instructions to call police if she is seen, having a code word for when someone needs help or needs the police to be called, keeping her office blinds open, and having others check in on her, especially if odd noises are heard. Beyond Dr. Smith’s office those who deal with client complaints against therapists should be made aware of the situation so that Meghan is unable to use this system to cause distress to or contact Dr. Smith (e.g., by filing complaints). A priority response should be placed on Dr. Smith’s home and workplace for the next 6 to 12 months so that police respond to calls in a timely manner. All four victims should be encouraged to call police immediately should Meghan contact them or engage in any stalking behavior. It would also be beneficial to discuss and develop safety plans with all four victims in the event that they come into contact with Meghan. Should there be a new female victim, either a new therapist or other professional (e.g., social worker, police officer, probation officer), similar safety strategies to those outlined above that are tailored to that victim’s work, home and travel, should be implemented and the victim should be counselled to terminate therapy or other contact with Meghan immediately.

Since Meghan will pose a risk to future female treatment providers a warning system among mental health professionals would be of use, as would education and other safeguards. Having said that, altering professional training and practice is beyond the scope of a single case analysis, thus, these issues will be considered in more detail in the discussion.

**Step 6: Conclusory Opinions**

Based on completion of the SAM, Meghan poses a high risk for continued stalking (case prioritization) and a low to moderate risk for serious physical harm. The risk of continued stalking is considered to be low to moderate for previous victims and high for a new female therapist. Overall, case prioritization is high as a substantial amount of effort will be required to prevent future stalking behavior. The victims, both past and present, showed reasonable fear in relation to the totality of circumstances. No immediate action is required in the case as Meghan has been convicted and will likely be bound by court ordered conditions restricting her behavior, which she has complied with in the past. This case should be reviewed when Meghan’s conditions change or expire and if those monitoring her (e.g., supervisor, treatment provider) note any major changes (e.g., decline in mental health, increased anger toward a previous victim) or red flags (e.g., she seeks out or obtains a new female therapist).

**Discussion**

**Summary of Findings**

The goals of the present paper were threefold. First, we wanted to demonstrate how an SPJ violence risk assessment instrument, specifically the SAM, can be used to assess and manage stalking risk. Second, through that case analysis we hoped to obtain an understanding of the motivation and dynamics of the stalking behavior described in the case. Third, as the case included the serial stalking of a specific professional type, mental health professionals, we hoped to highlight the risk that is posed to such professionals and derive a better understanding of the phenomenon.

The six steps of the SAM showed a great deal of interconnectedness in analyzing the present case with the early steps informing the later ones. For instance, motivation was ascertained based on the risk factors identified and risk formulation completed. First, the Nature of stalking risk factors were instrumental in identifying a possible secondary motivation for Meghan’s behavior, pleasure derived from being dominant to and controlling or tricking others. Second, the Perpetrator risk factor domain coupled with a root cause analysis highlighted the fact that Meghan was likely afflicted with an underlying mental health issue. This assisted in identifying the driving motivation for Meghan’s behavior, which would always begin as amorous or otherwise positive but would turn to anger and retaliation when she did not get her way.

Some limitations of the case analysis completed herein should be noted. First, a case analysis is only as good or as accurate as the information upon which it is based. Any case analysis should utilize all reliable and available information. Due to the public nature of this paper all possible sources of information were not available. Second, owing to privacy concerns some case information was not presented and some was altered. Since the aim of this paper was to demonstrate a method of violence risk assessment as opposed to accurately predict or prevent future violence we feel that these limitations do not detract greatly from the utility of the paper. Third, because a case study was used herein the results are limited in their generalizability with respect to the reliability and validity of threat assessment and management.

**Procedural Aspects of Violence Risk Assessment for Stalking**

Cook, Murray, Amat, and Hart (2014) raised several important points about the SPJ process and violence risk assessment generally in their case analysis. The points they discuss are directly relevant to the present case analysis and instead of repeating them we refer the reader to that discussion.

The SAM is only one of three available approaches to assessing risk in cases of stalking, the other two being the SRP and unstructured clinical judgement. These three approaches share similarities and differences. The introduction to this paper highlighted the major similarity between the SAM and the SRP, which is the SPJ method of violence risk assessment. This method distinguishes these two approaches from unstructured professional judgment, which by definition uses no structure instead relying entirely on the judgement of the evaluator conducting the assessment. The SPJ method values the judgment of the evaluator in weighting and combining information, however it provides guidelines on what information should be considered and how it should be combined. The reason for this structure to professional judgement is that there is little evidence that unstructured assessments are helpful in preventing violence or consistent across professionals (Hart, 2001).

Although based on the same underlying method, the SAM and the SRP have several major procedural differences. The first major difference is at what point in the assessment the evaluator should determine the motivation for the stalking behavior. In the SAM, the motivation is derived from the risk factors within the process of risk formulation. Thus, the motive is constructed or built as the evaluator moves from risk to relevance to formulation. This same process is also used by most other SPJ tools. In the SRP, motivation for the stalking behavior is determined at the outset of the assessment. The evaluator is guided in classifying the type of stalker being assessed (from the typology presented in Mullen, Pathé, Purcell, & Stuart, 1999), which is based on the initial or primary motivation of the stalker. Once determined, that motivational type then dictates a subset of the risk factors that should be considered in the case.

The second major difference is in the general structure of the risk judgement. In assessing overall risk, the SAM proceeds from the broad to the specific. Evaluators consider the prevalence and relevance of all risk factors, develop scenarios for future violence, management strategies for violence and then finally make specific risk determinations for Case prioritization, Continued stalking, and Serious physical harm. In contrast, in the SRP the specific risk judgements to be made determine what risk factors are to be considered. Evaluators make risk judgements for each of four risk domains, Risk for stalking violence, Risk of persistence, Risk of Recurrence, and Risk of psychosocial damage to stalker. The evaluation of risk for a particular domain is based on a combination of risk factors associated with that domain.

The third major difference is how the tools consider victim vulnerability. The SAM presents a structured way of assessing victim vulnerability. The third domain of the SAM is dedicated to identifying vulnerability factors specifically related to victims that should be considered in an assessment. The SRP does not designate a section or series of vulnerability factors related specifically to victims. Risk factors in the SRP are focused on the perpetrator, although some vulnerabilities related to victims are included within these risk factors (e.g., Awareness of victim location and accessibility of victim, Ongoing contact between victim and stalker). There is a small amount of research evidence (published and unpublished) establishing that the consideration of victim vulnerability is important to violence risk assessment (Belfrage & Strand, 2008; Reeves, 2008; Storey et al., 2009). No empirical evidence yet exists regarding the incremental predictive validity of victim vulnerability factors or whether they assist in risk prevention.

It is important to compare these different approaches to stalking risk assessment as any given approach filters information, highlighting some information and obscuring other information. It is therefore important to ascertain whether the approach you are using is missing information that is vital to the case. There are several ways in which these approaches can be tested. One method would be to conduct additional case studies to examine how each of the three approaches functions in practice. A second method would be through large scale empirical research. For instance, comparing assessments where the SAM or unstructured judgement was used in practice to identify how unstructured assessment is implemented, how experts interpret cases, whether unstructured judgment is identifying risk factors that are missed by structured instruments, and conversely whether professionals are missing risk factors when conducting their unstructured assessments. We believe it unlikely that unstructured judgement will outperform either SPJ tool given past findings about unstructured professional judgment, however, such research could illuminate current practices and identify additional variables of use in assessing and managing stalking.

Comparisons of the SAM and the SRP might seek to focus on the differences between the instruments, such as the three differences raised herein. For example, differential placement of motive identification within the instruments could be examined by comparing the interrater reliability of motives identified across evaluators. These two SPJ approaches to stalking assessment include different procedures which naturally suggest different avenues for research and it will be important to examine how well evaluators can utilize these approaches and how these approaches lend themselves to improving or expanding case analysis.

**Stalking of Mental Health Professionals**

The results, particularly the victim vulnerability factors, reveal that similar problems were faced by all four of the mental health professionals who were victimized by Meghan. Given these similarities, it seems likely that the findings are applicable beyond the current case and may suggest some areas of need and preventative efforts that could assist mental health professionals generally.

As previously noted, three of the four victims reacted in very similar ways and shared similar victim vulnerability factors. Although these similarities may be coincidental, it seems more probable that they were related to the victims’ shared profession and position in relation to Meghan. For instance, continuing therapy via providing Meghan with multiple chances to reform her behavior, minimizing the gravity situation, and feeling obligated to help her are understandable feelings and behaviors given the psychologists’ ethical duties and professional obligations toward Meghan. Meghan in turn used those professional obligations to manipulate her victims. First, she would fake crises to lengthen therapy sessions and avoid termination. These feigned crises preyed on the victims’ professional duty to assist and not abandon a client in need. A second manipulation by Meghan was that she tried to control the victims’ behavior by threatening to, and in some instances, filing complaints against them to their regulatory body. This was something her victims feared and noted as a reason for continuing to treat Meghan despite her stalking behavior.

Further, although not manipulative, Meghan benefited from other professional obligations held by her victims. First, despite knowing that her behavior was inappropriate the victims continued treatment out of professional obligation. Some of the victims did not call police, others did so only after the situation had escalated, at which point one victim still refused to press charges despite Meghan’s repeated breaches of police warnings. Although we cannot say with certainty why they did this, it is possible that the professional obligation to help and not harm a client (e.g., by getting them arrested) played a significant role. However, it is equally plausible that the decision not to act was driven by fear, either of retaliation by Meghan or by a concern that colleagues within the mental health profession would judge or criticize them for being stalked. In fact, research has shown this to be a valid concern as one study found that half of clinicians endorsed the view that poor clinical skill can increase stalking victimization (Storey, 2016). This view has no basis in empirical evidence, a patient’s decision to stalk their clinician is not the result of low clinical skill or experience (Pathé, 2014).

A second professional obligation that may have benefited Meghan was confidentiality. Through what may have been an attempt to maintain client confidentiality the victims told very few people about Meghan’s behavior. For example, only one victim warned other psychologists about accepting Meghan as a client. Although confidentiality is an important part of professional ethics there are limits regarding how far it can extend. For instance, the Tarasoff ruling(*Tarasoff v.*[*Regents of the University of California*](http://en.wikipedia.org/wiki/Regents_of_the_University_of_California), 1976) established a duty among mental health professionals to warn or protect individuals at risk from a client, allowing clinicians to break confidentiality. The duty to warn is now widely recognized outside of California through common law and statutory changes that have been made in many jurisdictions since the original ruling was made. What is less often discussed is what a clinician can and should do with respect to maintaining confidentiality when they find themselves at risk from a client.

The victim vulnerabilities identified herein therefore highlight areas of need and preventative efforts that can be taken by all mental health professionals. First is a need for education and training on the topic of stalking, which many mental health professional describe wanting (Storey, 2016). Despite the increased risk of being stalked compared to the general population, mental health professionals receive little to no training regarding how to deal with stalking or violent behavior directed at them by clients (Dinkelmeyer & Johnson, 2002; McIvor & Petch, 2006; Romans et al., 1996; Storey, 2016). In addition, the case examined herein seems to indicate that some of the current training and professional obligations of mental health professionals may make them more vulnerable once they are victimized (e.g., confidentiality, duty not to abandon a client in need). Mental health professionals might benefit from information on the nature and prevalence of stalking, how to set and maintain appropriate therapeutic boundaries, how to screen clients, how to create a safe work environment, how to identify stalking, when and how to refer a client, and what appropriate and ethical steps should be taken in these conflictual situations.

Second, there is a need for profession or workplace specific guidelines and policies regarding victimization. The need for policies as well as services to assist those who are victimized has also been suggested elsewhere (McIvor & Petch, 2006; Storey, 2016; Whyte et al., 2011). As Pathé (2014) emphasized in relation to the management model forwarded by Carr and colleagues (2014), the management of stalking requires systemic interventions implemented by the victim’s employer. It may be difficult for therapists who work independently in small private practices to develop specific workplace guidelines around these issues. In such cases, professional bodies can and should help take the lead in developing guidelines and practice support documents around issues of victimization that can then be adapted by individual therapists. Policy makers and clinicians might also consider addressing the issue of forewarning mental health professionals about clients with a history of violence toward clinicians. In other professions (e.g., policing, medicine), documenting a client’s proclivity for violence toward professionals providing services and sharing that information with those professionals is common practice. Professional groups should also consider examining the process through which official complaints are handled where allegations of stalking or other criminal behavior by a client have been made. The use of official complaints against professionals to further harass or communicate with these victims is not uncommon. Although complaints cannot be blindly dismissed there may be a way to reduce the hardship on victims and rewards for perpetrators in cases where evidence of illegal behavior on the part of the client toward the clinician exists. Clear regulations regarding complaints might also encourage mental health professionals to report victimization, as Dr. Smith did note that her fear of retaliation caused her to delay reporting.

Finally, we would like to note that the intention of the present paper was not to criticize the behavior of any group or individual. We believe strongly that victims are never to blame for crimes committed against them. Our intent was to use this case study for a positive purpose, namely to highlight an important issue and describe its assessment and management in the hopes of helping others in similar situations and to suggest changes that can be made to professional practice in order to assist future victims and prevent future stalking and violence.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association (2010). 2010 Amendments to the 2002 "Ethical principles of psychologists and code of conduct". *American Psychologist, 65*, 493.

Basile, K. C., Swahn, M. H., Chen, J., & Saltzman, L. E. (2006). Stalking in the United States recent national prevalence estimates. *American Journal of Preventive Medicine, 31*, 172-175. doi:10.1016/j.amepre.2006.03.028

Belfrage, H., & Strand, S. (2008). Validation of the stalking and management checklist (SAM) in law enforcement: A prospective study of 153 cases of stalking in two Swedish police counties. *International Journal of Police Science and Management, 11*, 67–76. doi:10.1350/ijps.2009.11.1.110

Brown, G. P., Dubin, W. R., Lion, J. R., & Garry, L. J. (1996). Threats against clinicians: A preliminary descriptive classification. *The Bulletin of the American Academy of Psychiatry and the Law, 24,* 367-376.

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

*Canadian Criminal Code*, R.S.C. 1985, Chap. C-46, as amended s. 264(1).

Carr, M. L., Goranson, A. C., & Drummond, D. J. (2014). Stalking of the mental health professional: Reducing risk and managing stalking behavior by patients. *Journal of Threat Assessment and Management, 1*, 4–22. doi: 10.1037/tam0000003

Cook, A. N., Murray, A. A., Amat, G., & Hart, S. D. (2014). Using structured professional judgment guidelines in threat assessment and management: Presentation, analysis, and formulation of a case of serial intimate partner violence. *Journal of Threat Assessment and Management, 1*, 67-86. doi: 10.1037/tam0000011

Dinkelmeyer, A., & Johnson, M. B. (2002). Stalking and harassment of psychotherapists. *American Journal of Forensic Psychology, 20*, 5–20.

Foellmi, M. C., Rosenfeld, B., & Galietta, M. (2016). Assessing risk for recidivism in individuals convicted of stalking offenses: Predictive validity of the guidelines for stalking assessment and management. *Criminal Justice and Behavior*, *43*(5), 600-616. doi: 10.1177/1073191116653470

Galeazzi, G. M., & De Fazio, L. (2006). A review on the stalking of mental health professionals by patients, prevention and management issues. *Primary Care and Community Psychiatry, 11,* 57-66. doi: http://dx.doi.org/10.1185/135525706X105046

Galeazzi, G. M., Elkins, K., & Curci, P. (2005). Emergency psychiatry: The stalking of mental health professionals by patients. *Psychiatric Services, 56*, 137–138. doi: 10.1176/appi.ps.56.2.137

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

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

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

Kropp, P. R., Hart, S. D., & Lyon, D. R. (2002). Risk assessment of stalkers: Some problems and possible solutions. *Criminal Justice and Behavior, 29,* 590-616. doi: 10.1177/009385402236734

Kropp, P. R., Hart, S. D., Lyon, D. R., & Storey, J. E. (2011). The development and validation of the guidelines for stalking assessment and management. *Behavioral Sciences and the Law, 29,* 302-316. doi: 10.1002/bsl.978

Leavitt, N., Presskreischer, H., Maykuth*,* P. L., & Grisso, T. (2006). Aggression toward forensic evaluators: A statewide survey. *Journal of the American Academy of Psychiatry and the Law, 34,* 231-239.

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

Lloyd-Goldstein, R. (2000). Serial stalkers: recent clinical findings. In: Schlesinger L. (Ed.). Serial offenders: current thoughts, recent findings. Boca Raton, FL: CRC Press, 2000:167-185.

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

McIvor, R. J., & Petch, E. (2006). Stalking of mental health professionals: An under-recognised problem. *British Journal of Psychiatry, 188*, 403-404. doi: 10.1192/bjp.bp.105.018523

Meloy, J. R., & Boyd, C. (2003). Female stalkers and their victims. *Journal of the American Academy of Psychiatry and the Law, 31*, 211–219.

Mullen, P. E., Pathé, M., Purcell, R., & Stuart, G. W. (1999). Study of stalkers. *American Journal of Psychiatry, 156*, 1244-1249.

Pathé, M. (2014). Comment: Guiding mental health professionals through murky waters. *Journal of Threat Assessment and Management, 1*, 25-26. doi: 10.1037/tam0000001

Petherick, W. (2009). Serial stalking: Looking for love in all the wrong places? In W. Petherick (Ed.), *Serial Crime: Theoretical and Practical Issues in Behavioral Profiling* (2nd ed.)(pp. 257-281). Burlington, MA: Elsevier Academic Press.

Purcell, R., Pathé, M., & Mullen, P. E. (2001). A study of women who stalk. *American Journal of Psychiatry, 158,* 2056-2060. doi:10.1176/appi.ajp.158.12.2056

Purcell, R., Powell, M. B., & Mullen, P. E. (2005). Clients who stalk psychologists: Prevalence, methods, and motives. *Professional Psychology: Research and Practice, 36,* 537-543. doi: 10.1037/0735-7028.36.5.537

Reeves, (2008). *The decision-making and stalking risk study*. Simon Fraser University, Burnaby, British Columbia, Canada.

Regehr, C., & Glancy, G. D. (2011). When social workers are stalked: Risks, strategies, and legal protections. *Clinical Social Work Journal, 39*, 232-242. doi 10.1007/s10615-010-0303-4

Romans, J. S. C., Hays, J. R., & White, T. K. (1996). Stalking and related behaviors experienced by counseling center staff members from current or former clients. *Professional Psychology: Research and Practice, 27*, 595-599. doi:10.1037/0735-7028.27.6.595

Smoyak, S. (2003). Perspectives of mental health clinicians on stalking continue to evolve. *Psychiatric Annals 33*, 641-648.

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

Storey, J. E. (2014). Commentary on Carr, Goranson, and Drummond (2014). *Journal of Threat Assessment and Management, 1*, 23-24. doi: 10.1037/tam0000009

Storey, J. E. (2016). Hurting the healers: Stalking and stalking-related behaviour perpetrated against counsellors. *Professional Psychology: Research and Practice, 47*(4), 261-270. doi: org/10.1037/pro0000084

Storey. J. E., & Hart, S. D. (2011). How do police respond to stalking? An examination of the risk management strategies and tactics used in a specialized anti-stalking law enforcement unit. *Journal of Police and Criminal Psychology, 26*, 128-142. doi 10.1007/s11896-010-9081-8

Storey, J. E., Hart, S. D., Meloy, J. R., & Reavis, J. A. (2009). Psychopathy and stalking. *Law and Human Behavior,* *33,* 237-246. doi:10.1007/s10979-008-9149-5

*Tarasoff v.*[*Regents of the University of California*](http://en.wikipedia.org/wiki/Regents_of_the_University_of_California), 131 Cal. Rptr. 14, 551 P.2d 334 (1976).

Whyte, S., Penny, C., Christopherson, S., Reiss, D., & Petch, E. (2011). The stalking of psychiatrists. *International Journal of Forensic Mental Health, 10*, 254-260. doi: 10.1080/14999013.2011.599097

Table 1

*Timeline of Stalking Perpetrated by Meghan Against Four of her Psychologists*

|  |  |
| --- | --- |
| Date | Description of major events |
| 1992 | Meghan becomes a client of Dr. Walters. |
| 1993 | Meghan becomes a client of Dr. McGee.Dr. Walters terminates therapy with Meghan. |
| 1994 | Dr. McGee terminates therapy with Meghan and gets an 810 peace bond against her. Meghan tries to solicit help from Dr. Walters to get the 810 peace bond lifted. |
| 1995 | Meghan requests that Dr. Walters continue treating her or refer her to another female mental health professional. |
| 2000s | Meghan is treated by two male mental health professionals, no problems arise. |
| 2007 | Meghan becomes a client of Dr. Betts. |
| 2009 | Meghan makes a request to become a client of Dr. Smith. |
| 2010 | Meghan becomes a client of Dr. Smith. |
| 2011 | Dr. Smith terminates therapy with Meghan. Meghan is arrested and charged for criminal harassment and assault of Dr. Smith. |

Table 2

*Presence of SAM Risk Factors at the Time of Stalking by Victim*

|  |  |
| --- | --- |
| SAM risk factors | Pattern of stalking behavior |
| Pattern of stalking 1: Dr. Walters | Pattern of stalking 2: Dr. McGee | Pattern of stalking 3: Dr. Betts | Pattern of stalking 4: Dr. Smith |
| N1. Communicates about victim | ø | ● | ● | ● |
| N2. Communication with victim | ● | ● | ● | ● |
| N3. Approaches victim | ● | ● | ● | ● |
| N4. Direct contact with victim | ● | ● | ● | ● |
| N5. Intimidates victim | ● | ø | ● | ● |
| N6. Threatens victim  | ø | ø | ø | ø |
| N7. Violent toward victim  | ● | ø | ø | ● |
| N8. Stalking is escalating  | ● | ○ | ● | ● |
| N9. Stalking is persistent  | ● | ø | ● | ● |
| N10. Stalking involves supervision violations | ø | ø | ● | ø |
| Other considerations related to the nature of the stalking: | ø | ø | ø | ø |
| P1. Angry | ● | ● | ● | ● |
| P2. Obsessed | ● | ● | ● | ● |
| P3. Irrational | ø | ø | ø | ø |
| P4. Unrepentant | ● | ● | ● | ● |
| P5. Antisocial lifestyle | ø | ø | ø | ø |
| P6. Intimate relationship problems | ● | ● | ● | ● |
| P7. Non-intimate relationship problems | ● | ● | ● | ● |
| P8. Distressed | ○ | ○ | ○ | ○ |
| P9. Substance use problems | ø | ø | ø | ø |
| P10. Employment and financial problems | ø | ø | ø | ○ |
| Other considerations related to the perpetrator: Unresolved issues with her sexuality | ● | ● | ● | ● |
| V1. Inconsistent behavior toward perpetrator | ● | ø | ● | ● |
| V2. Inconsistent attitude toward perpetrator | ○ | ø | ○ | ● |
| V3. Inadequate access to resources | ø | ø | ø | ø |
| V4. Unsafe living situation | ● | ○ | ○ | ○ |
| V5. Problems caring for dependents | ø | ø | ø | ø |
| V6. Intimate relationship problems | ø | ø | ø | ø |
| V7. Non-intimate relationship problems | ø | ø | ø | ø |
| V8. Distressed | ø | ø | ø | ø |
| V9. Substance use problems | ø | ø | ø | ø |
| V10. Employment and financial problems | ø | ø | ø | ø |
| Other considerations related to the victim: | ø | ø | ø | ø |

*Note*. SAM = *Guidelines for Stalking Assessment and Management* (Kropp et al., 2008).
● = Present, ○ = Possibly or partially present, ø = Absent.

**Appendix**

**Case Summary**

**Personal history.** Meghan Stanley was born in 1970 in Ireland and moved to Canada with her family when she was seven years old. Meghan’s family consists of her mother, father and one sister. The quality of the relationship that Meghan currently holds with her immediate family is unknown. Her childhood was uneventful except for a romantic relationship she had with an older woman when she was 17. The relationship resulted in some confusion regarding her sexual orientation. Megan later married a man named Brent but they divorced in 2011. Meghan stated that the divorce was caused by Brent’s infidelity and that she had found his affair to be devastating. The couple did not have any children.

Meghan reports that she has friends whom she sees occasionally. It is unclear whether Meghan is currently employed. She has aspirations of working as a home care nurse. Meghan completed high school and a few years of post-secondary study. In the past she has worked as a waitress and a receptionist. Between 2010 and 2012 she worked part time and was unemployed for a 6-month period in 2011. There is no evidence that Meghan abuses substances.

**Stalking history.** In 1992 at the age of 22 Meghan began seeing a psychologist named Dr. Rebecca Walters. One of the primary reasons that she sought therapy was due to her prior romantic relationship with an older woman and her current confusion regarding her sexual orientation.

Early on in therapy Meghan began to display problems with the therapeutic relationship, particularly with respect to maintaining appropriate boundaries. Meghan would phone Dr. Walters dozens of times a week, claiming to be in crisis and in need of an extra therapy session. On two occasions when their sessions concluded, Meghan refused to leave the office and blocked Dr. Walters from leaving. On one of those occasions Dr. Walters was trapped in her office until a colleague opened the door to check on her. After the second time that Meghan refused to leave her office, Dr. Walters drew up a contract outlining appropriate client conduct. The contract restricted Meghan to one phone call per week and to leaving when her session was over. Any breaches of the contract were subject to therapeutic termination. Meghan agreed to the contract.

Soon after implementing the contract Dr. Walters began to see Meghan in her neighborhood, in both the stores and parks that she frequented. Dr. Walters decided to refer Meghan to Dr. Tamara McGee in the hopes of finding a way to resolve her behavioral issues and continue treating Meghan. In her sessions with Dr. McGee, Meghan revealed that she felt loved and cared for by Dr. Walters and was sexually attracted to her which she felt was interfering with therapy. When Dr. Walters learned of Meghan’s feelings she decided the best course of action was to terminate therapy with Meghan.

Therapy with Dr. McGee continued but quickly began to resemble what had occurred with Dr. Walters. Meghan began following Dr. McGee in her car, showing up at stores she frequented, besetting her office and her daughter’s school, making hang-up telephone calls, and volunteering at locations where Dr. McGee’s friends were employed. On one occasion Meghan went to Dr. McGee’s apartment and banged on her door repeatedly until Dr. McGee called police. On another occasion Dr. McGee learned that Meghan had been telling other tenants in her building that she and Dr. McGee were friends and that she was helping Dr. McGee because Dr. McGee was being stalked.

The final straw for Dr. McGee was a phone call that she received from a friend of Meghan’s. The friend suspected that something was amiss with Meghan and decided to call individuals whom Meghan had told her about to check-up on the stories that she had been told. The friend told Dr. McGee that Meghan had described the psychologist as a very close friend who was being stalked by a dangerous person and that Meghan was worried for her safety. Dr. McGee felt that this was a veiled threat and decided to terminate therapy and involve police. Dr. McGee also decided to warn other psychologists against accepting appointments with Meghan, an act that resulted in Meghan making a complaint to the college of psychologists against Dr. McGee. As a result of Meghan’s behavior and Dr. McGee’s fear for her safety, Dr. McGee received a one-year section 810 peace bond (also known as a criminal restraining order) against Meghan. In abidance with the order Meghan ceased contact with Dr. McGee but did unsuccessfully attempt to have the peace bond lifted after 6 months.

Despite ceasing her stalking of Dr. McGee Meghan did contact Dr. Walters. Meghan barged into Dr. Walters’ office and asked her to intervene on her behalf with Dr. McGee to get Dr. McGee to drop the peace bond against her. Dr. Walters was fearful and asked Meghan to leave, she refused. The situation escalated to where Meghan forcefully kept Dr. Walters in her office for two and a half hours. Meghan said that she had nothing left to lose if therapy was over. A physical confrontation then occurred where Meghan pushed Dr. Walters down and tried to take her keys so she could not leave. The situation ended when, out of fear, Dr. Walters promised to see Meghan again.

After consulting with colleagues Dr. Walters decided that she should not have any more contact with Meghan. When Dr. Walters told Meghan this by phone Meghan was agreeable. However, one week later Dr. Walters saw Meghan outside of her apartment building staring inside. Dr. Walters then sent Meghan a letter asking that Meghan have no more contact with her. Meghan admitted to following and besetting Dr. Walters but promised to stop if they could have one last amicable goodbye. Dr. Walters refused and decided to move residences. Over time and through various sources Dr. Walters learned that many of the problems that Meghan had purported to have in therapy were fabricated.

Approximately one year later, in 1995, Meghan showed up at Dr. Walters’ office. Meghan was told to leave, and did so, but later called to say that she would like to resume therapy with Dr. Walters. Dr. Walters responded by letter, stating that she no longer wanted any contact with Meghan. Meghan responded by leaving a voice mail message for Dr. Walters stating that the letter made her angry and asking for a reference to see another female psychologist. Dr. Walters refused to provide her with such a reference. From this encounter until 2002 Dr. Walters says that she has run into Meghan approximately twice a year and that Meghan occasionally sends her post cards and letters. In total, contact from Meghan toward Dr. Walters continued off and on for approximately a decade.

Following the termination of her treatment with Dr. McGee, Meghan was briefly treated by a male psychologist. Treatment lasted only a few months and the psychologist reported no harassing or stalking behavior. Meghan was then under the care of a male psychiatrist until 2007. The psychiatrist described Meghan as having an obsessional disorder and as being fearful of abandonment. He further stated that to avoid such abandonment she would go to extremes to maintain her relationships. The psychiatrist did not report any issues with harassment or stalking behavior perpetrated by Meghan toward himself.

In 2007 Meghan began to see a new psychologist, Dr. Emma Betts. Meghan was introduced to Dr. Betts when Dr. Betts briefly substituted for Dr. Walters years earlier. Similar inappropriate and harassing behavior began early in the therapeutic relationship, including a high volume of distress calls, boundary violations, breaking down at the end of sessions and refusing to leave, fabricating the issues they worked on in therapy, attending stores frequented by Dr. Betts and others close to Dr. Betts, and becoming sexually infatuated with Dr. Betts.

Dr. Betts determined that in light of the boundary violations, the fabrication of therapeutic issues, and the romantic feelings that Meghan had toward her, she could no longer effectively treat Meghan, so she attempted to terminate therapy. Meghan responded by refusing to end the session and blocking Dr. Betts from exiting her office for several hours. Dr. Betts eventually had to promise to see Meghan for another session and threaten to call police before Meghan left her office. Dr. Betts later informed Meghan by mail that an additional session would not be granted.

Following termination Meghan repeatedly called and sent letters to Dr. Betts, she also showed up at her office and demanded to speak with Dr. Betts until staff members threatened to call police. In response to this incident, Dr. Betts sent a letter to Meghan requesting no further contact. When Meghan persisted, Dr. Betts phoned the police and brought Dr. Walters, whom she recently learned had experienced similar problems with Meghan, to the station with her to make a statement. The police issued three warnings to Meghan, instructing her to cease her behavior or face criminal harassment charges. Police issued more than one warning without making an arrest because Dr. Betts did not want to press charges. The first two warnings were unsuccessful in deterring Meghan’s behavior and the third warning coincided with Meghan making a complaint against Dr. Betts to the college of psychologists. After the third warning Dr. Betts also received anonymous phone calls from payphones and several requests from Meghan for Dr. Betts to provide her with her treatment file. At this time Meghan also sent a letter to Dr. Walters indicating that she knew personal information about her.

As part of the third police warning Meghan took part in an interview conducted by a male psychologist, Dr. Wong. Meaghan brought her husband to the interview. In the interview Meghan said that she did not understand why therapy with Dr. Betts had been terminated and provided what she felt were explanations for her behavior. Meghan stated that she thought it was okay to call Dr. Betts between sessions because Dr. Betts called her back, and that it was okay to exceed her allotted time in session because Dr. Betts always extended her session time. She further explained that she remained in contact with Dr. Betts because, Dr. Betts told her they could meet again six months after therapy was terminated, that Dr. Betts had not requested ‘no contact’, that Dr. Betts said she could write to her if she had problems, and that she had to return a book that Dr. Betts had loaned her. Sometime soon after the third police warning and interview Meghan’s stalking of Dr. Betts ceased (exact end dates cannot be specified due to the covert nature of much of Meghan’s stalking behavior) and a complaint was filed with the college of psychologists about Dr. Betts by Meghan.

Most recently Meghan has been seeing a new female psychologist, Dr. Laurel Smith. In addition to having a private practice Dr. Smith also makes television appearances where she provides therapeutic advice. In February of 2009 Meghan made a request to become a client of Dr. Smith. Dr. Smith told Meghan that based on her treatment needs she was not the appropriate therapist for her. In response, Meghan left several angry voice-mail messages for Dr. Smith.

In January of 2010 Meghan returned to see Dr. Smith stating that she had been treated by another psychologist who had suggested that Dr. Smith take her on as a client. Dr. Smith agreed and took Meghan on as a client. Meghan’s behavior toward Dr. Smith quickly became inappropriate. Meghan would leave 10 to 15 voice-mail messages between sessions as well as send multiple emails, some of which were hostile and abusive. In addition, Meghan began violating therapeutic boundaries by calling Dr. Smith’s unlisted cell phone number and waiting outside her office to see who picked Dr. Smith up from work. Meghan also admitted to having sexual fantasies about Dr. Smith.

The boundary violations escalated and on two occasions Meghan blocked Dr. Smith’s office door and refused to let Dr. Smith leave after their session was over. On the second occasion when she blocked the door Meghan also hit her own head against the wall and used a paper weight to hit herself in the head. When Dr. Smith tried to leave the office, Meghan slapped her hand and shoved her away from the door. No one else was in the office at the time so to escape the situation Dr. Smith agreed to see Meghan for another session and also threatened to call police if she did not leave. After the incident Meghan called Dr. Smith repeatedly to apologize for her behavior. At this time Dr. Smith also learned that Meghan had joined several of the social groups that she was a member of and was asking other members personal questions about her.

During their next session Dr. Smith told Meghan that because of her behavior therapy would have to be terminated unless she agreed to and completed three tasks. First, Meghan was to undergo a psychiatric assessment to identify any mental health issues she might have. Second, Meghan had to cease participating in any groups that Dr. Smith was also a member of. Third, Meghan had to stop asking others and otherwise searching for information about Dr. Smith. Soon after they agreed upon these terms Meghan returned to therapy stating that she had completed all three requirements. Meghan however refused to share the assessment results with Dr. Smith or offer proof that an assessment had taken place. As a result, Dr. Smith decided that it was best to terminate therapy, Meghan responded by claiming that she was in crisis due to some recent and negative major life events. Not wanting to abandon her client, Dr. Smith continued therapy. However, she decided to look into the veracity of the crisis that Meghan had described, something that quickly snowballed into additional research on Meghan’s background and the claims she had made in therapy due to the inaccuracies found in Meghan’s story.

Through her research Dr. Smith learned that her first contact with Meghan was not, as she thought, when Meghan requested to be her client—it was through the television program she was occasionally a guest on. In fact, Meghan had developed at least 25 personas that she used to call and write into the program to ask Dr. Smith for advice; one such persona had been abusive and critical toward Dr. Smith. Dr. Smith also learned that Meghan had been sending her emails posing as her ex-husband and her friends, as well as emailing Dr. Smith’s family and friends posing as Dr. Smith. As a result, Meghan had amassed a great deal of personal information about Dr. Smith. Dr. Smith further discovered that much of what had been discussed and worked on in therapy was based on lies; Meghan had created fake family members, friends, jobs, and relationships with other psychologists. Dr. Smith also found out about the episodes of stalking experienced by Dr. Walters, Dr. McGee, and Dr. Betts.

Dr. Smith realized that although she initially put off termination due to her minimization of the situation, her feelings of professional obligation toward Meghan, and her fear that Meghan would retaliate against her professionally by making complaints to her professional body, she had now reached a point of constant fear and needed to act. Dr. Smith confronted Meghan about what she had discovered in their next session. Meghan admitted to everything including that she was spending between five and six hours a day engaging in stalking behavior toward Dr. Smith. Meghan attempted to make reassurances to Dr. Smith, “I will never hurt you”, “I will never come to Gladstone” (the area where Dr. Smith lived), “I have never been there except to drive through”, but Dr. Smith found these reassurances to be more akin to veiled threats. Dr. Smith terminated therapy, at which time Meghan claimed she needed to go to the bank to withdraw money to pay for the session. Dr. Smith said that she could do so but would have to leave the money with her secretary upon her return. Meghan then refused to leave the office, blocked Dr. Smith from the door, slapped her hand away from the door, and shoved her. Dr. Smith called 911 and Meghan left. Meghan returned to the office soon after with the money for the session, again refusing to leave until police were called.

Following termination, Dr. Smith received phone calls and letters from Meghan requesting, a final therapy session to say goodbye nicely, a receipt for her final therapy session payment, and her treatment file. Dr. Smith consulted with colleagues and attorneys and ultimately decided to call police and request that charges be laid against Meghan. Meghan was subsequently charged with two counts of criminal harassment and one count of assault in December of 2011. Dr. Smith assisted police in their investigation by writing a detailed statement, providing the names of those who could corroborate her statement, and turning over all the communication she had received from Meghan (emails, voice messages, etc.) to police. Meghan was ultimately convicted of criminal harassment and is awaiting sentencing.