
The management of stalkers

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Stalking (Box 1) has only recently been distinguished from a wide range of other socially inappropriate, intrusive and potentially distressing activities. It is now a specific form of criminal offending and has established itself as a recognised social problem (Melo, 1998; Mullen *et al*, 2000). Stalking may well reflect, as Emerson *et al* (1998) argue, “intricate social processes”, but if the psychopathology of the stalker is a necessary, even if far from sufficient, cause then treating that psychopathology may end the stalking (Mullen & Pathé, 2001).

There are no published evaluations of treatment interventions in stalking. The literature consists of occasional papers in which clinicians comment on their own practice or academics argue for the relevance of approaches developed in related fields, such as the management of spousal abusers (Westrup, 1998; White & Cawood, 1998; Mullen *et al*, 2000; Rosenfeld, 2000). Rosenfeld (2000), in the most extensive and sensible account to date of the management of stalkers, notes in conclusion that although no treatments of obsessional harassment (his preferred name for stalking) have been proposed or systematically studied, there are grounds for “guarded optimism that effective treatments may exist” (p. 547). In well-established areas of clinical practice it is usually possible to provide succinct summaries of the relevant literature on treatment. The less that is known the longer and more convoluted become discussions of management. In stalking, where no established guidelines exist, the reader is not only exposed to length, but is at the mercy of the prejudices and foibles of the writers: *caveat emptor*.

Mental health professionals can take a remarkably narrow view of their areas of responsibility and competence. This narrowness is encouraged by scant resources and by training programmes that elevate serious mental disorder not just to the core business of psychiatric services but to the only business of such services. The management of stalkers would, from such perspectives, have difficulty establishing itself as a legitimate activity. It needs to be emphasised, however, that this is not a matter of medicalising deviancy. Therapeutic interventions are directed first at the mental disorders so often associated with stalking and second at employing well-established psychological and psychiatric techniques to reduce the disabilities that frequently underlie the behaviour. That the use of mental health professionals’ knowledge and skills in this area also contributes to reducing victimisation and criminal offending is surely a bonus rather than a reason for withdrawing our professional concern.

The clinical management of stalkers is based first and foremost on the nature of any mental disorder

Box 1 What is stalking?

Stalking is a behaviour characterised by repeated intrusions involving:

Unwanted contacts, including following, approaches and surveillance

Unwanted communications, including telephone calls, e-mails, letters and graffiti

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contributing to sustaining the harassment. The motivation of the stalker for initiating and, perhaps more important, continuing the stalking is relevant to management. Our clinic employs a typology based on motivational factors, which divides stalkers into the rejected, the intimacy seekers, the incompetent suitors, the resentful and the predatory (Mullen *et al*, 1999). In almost all stalkers there is a need both to improve interpersonal and social skills and to instil a more realistic understanding of the impact of their behaviour on victims. Any substance misuse problems must also be addressed.

In most jurisdictions the courts have the power to order mandatory assessment and treatment of stalkers. It is through such powers that most stalkers are brought into contact with mental health services. In practice, that opportunity for therapeutic intervention is sometimes ignored by the courts, perhaps from ignorance or from prior experiences of unhelpful responses from mental health professionals. In recalcitrant cases it may be that it is only through imprisonment, which incapacitates the stalker, at least for a period, that any peace or protection can be brought to the victim. If that relief is not to be limited to the length of the incarceration then in many cases therapeutic interventions are necessary, either during imprisonment or immediately on return to the community.

This paper will briefly look at the basic approach to the assessment and management of stalkers (a subsequent paper (Pathé *et al*, 2001) will consider the management and treatment of the victim of stalking).

The nature of stalking and stalkers

Stalking consists of a constellation of behaviours involving repeated and persistent attempts to impose unwanted communications and/or contacts in a manner that is likely to induce fear in a normal person (Meloy & Gothard, 1995; Pathé & Mullen, 1997; Westrup & Fremouw, 1998). Communications include telephone calls, letters, electronic mail and notes attached to property. Contacts can be via following, intrusive approaches, maintaining surveillance on the victim's home or place of work and loitering in the victim's vicinity. There are a number of behaviours that, although not part of the core constellation, are frequently associated with stalking; these are listed in Box 2.

At one end of the spectrum, stalking behaviours merge into the all too common episodes of ill-considered intrusiveness, which, although they may

Box 2 Behaviours associated with stalking

Threats
Assault
Ordering or cancelling goods or services on the victim's behalf
Sending unsolicited gifts
Initiating spurious legal actions
Making vexatious complaints

be distressing, are fortunately short lived. At the other end of the spectrum, stalking can represent intense campaigns of harassment that last for years and lay waste to the social and psychological health of the victim.

In theory, stalking behaviours could be indulged in by individuals with no particular psychiatric or psychological problems. In practice, once you move beyond brief episodes of harassment to campaigns of intrusiveness that last for months or years it is rare to encounter perpetrators without evidence of obvious mental disorder.

General principles of management

The effective control of stalking behaviour is usually best achieved by an appropriate balance of judicial sanctions and therapeutic interventions. The principal aspects of clinical management are shown in Box 3.

Box 3 Clinical management of stalking behaviour

Clinical management is based on
The nature of the contributory mental disorder
An understanding of what is sustaining the behaviour
Confronting the almost universal self-deceptions, which deny, minimise or justify the behaviour
Instilling at least a modicum of empathy for the victim's plight
Addressing the stalker's rudimentary, or inappropriate, social and interpersonal skills
Combating substance misuse

Stalkers, we believe, should be managed individually and group work avoided, because, like sex offenders, stalkers readily establish networks of mutual support and information-sharing within a group.

Managing contributory mental disorders

A number of delusions can be associated with stalking. Most frequently encountered are erotomanic delusions, in which the patient is convinced that the object of his or her (unwanted) attentions reciprocates the affection or will, given time and opportunity, come to share a desire for intimacy (Goldstein, 1978; Leong, 1994; Mullen & Pathé, 1994a; Harmon *et al*, 1995). Erotomanic delusions can be encountered secondary to any condition in which delusions develop. The literature suggests that erotomanic syndromes respond poorly to treatment (Segal, 1989; Gillett *et al*, 1990; Leong, 1994). Mullen & Pathé (1994a,b) believe that this therapeutic pessimism is misplaced. They suggest that usually the response of symptomatic disorders to treatment reflects the nature of the underlying psychosis, whereas delusional disorders usually respond to a combination of low doses of antipsychotics and supportive psychotherapy. In delusional disorders specific claims for the efficacy of pimozide have been advanced (Munro *et al*, 1985; Stein, 1986; Munro & Mok, 1995). In our experience the nature of the antipsychotic is less important than the avoidance of side-effects, which reduce compliance. To this end we favour the newer antipsychotics, with low starting doses and only gradual increments. When the patient's only acknowledged problem is the difficulty in pursuing a quest for future love it is difficult enough to persuade him or her to take medication without also having to battle against intrusive side-effects.

The management of erotomanic syndromes, in particular in the delusional disorders, cannot be reduced only to ensuring medication compliance. The preoccupation with the supposed beloved has usually come to occupy the centre of the patient's life. The pursuit is not just a quest, it is often the organising principle around which the patient's current existence and future hopes revolve. To sustain their fantasies, individuals with erotomania must ignore, or reinterpret, both the manifest rejections and the price they are paying for the pursuit in terms of time, money, disappointment and, potentially, criminal sanctions. Simply pointing out the erroneous nature of their beliefs is, as with most

deluded patients, productive more often of conflict than progress. However, repeatedly drawing attention to the personal costs of continuing the pursuit and gently urging the patients to consider the likely implications of rebuffs and rejections can, over time, produce benefit. The person with erotomania is like the persistent gambler, who, having sacrificed everything in the unproductive pursuit, is trapped because the only solution seems to be to continue the behaviour in the hope of a change of luck. Such individuals need to be offered both an excuse to stop and some face-saving exit; offered not once but repeatedly over time.

The erotomanic type of delusion predominates in stalking, but delusions of jealousy, persecutory delusions, querulant delusions and misidentification syndromes are also encountered. Management differs little from that of the erotomanic syndromes, although it should be remembered that the risk of escalation to violence is probably more marked, particularly in delusions of jealousy.

Stalking behaviour is sometimes seen in manic states either as part of a general intrusiveness and disinhibition or secondary to the emergence of erotomanic preoccupations. Such episodes, although intense and frightening, are rarely prolonged. However, although the distractibility and lability of mania mitigates against sustaining either preoccupations or courses of conduct, occasionally patient with mania will persistently harass someone on whom they have focused their affection or animus. Resolution of the mood disorder usually terminates the behaviour.

Not surprisingly, a behaviour characterised by repetition and by what on occasion amounts to a total preoccupation with the victim has been labelled *obsessional*. Occasionally, stalkers are encountered whose preoccupation with, and pursuit of, the target of their unwanted attentions has *obsessional* features. The preoccupations and actions are recognised by the stalker as irrational, or at least absurdly persistent. There are attempts to resist both the ruminations and the behaviour, and there are elements both of anxiety reduction and regret in the performance of what is sometimes a partially ritualised pursuit. Such cases are, however, the exception rather than the rule. Far more common are stalkers who happily indulge in their harassment and the associated fantasies, or who deny that the behaviour is in any way remarkable, let alone damaging and criminal. That many stalkers are committed to the pursuit is certain, that they are obsessed in the everyday sense with the victim is undoubted, but what seems far more dubious is that, other than in the occasional case, they can usefully be regarded as having obsessions, let alone an *obsessional* disorder.

High rates of personality disorders have been found in studies of stalkers (Meloy & Gothard, 1995; Harmon *et al*, 1998; Mullen *et al*, 1999). Paranoid, dependent, narcissistic and antisocial personality disorders appear to predominate. In clinic samples between 30 and 50% of subjects have been given a primary diagnosis of personality disorder (Harmon *et al*, 1998; Mullen *et al*, 1999). In managing stalkers the focus is not on the personality disorder *per se* but on those aspects that sustain the behaviour. For example, the sense of entitlement in the narcissistic, the refusal to disengage in the dependent and the self-referential tendencies of the paranoid are addressed in the specific context of their stalking behaviour. Equipping the patient with a shiny new 'class A' personality is not the aim, just modest realignments of attitudes and behaviour in the situations critical to stalking. Even that is no easy task.

In the narcissistic, for example, the initial focus tends to be on the costs to the individual in terms of lost time, spent resources and personal humiliation. Given that such people tend to be more alive to their own interests and feelings than to those of others it is usually possible to persuade them of the absurdity of continuing the pursuit ("Why is someone like you wasting your time and energies on someone like that?"). The manipulative nature of such an approach, it has to be acknowledged, is reprehensible, the only excuse being that it can work to the benefit of both patient and victim.

Typology and management

A number of classifications and typologies for stalkers have been advanced (for discussion see Mullen *et al*, 2000). Our typology (summarised in Box 4 and discussed below) is based primarily on motivation and context, and it was developed to guide management (Mullen *et al*, 1999, 2000). The types are not always mutually exclusive but in the majority of cases we find little difficulty assigning the individual to a particular category.

The rejected stalker

The rejected stalker is the most common type encountered in our practice. In this group the stalking emerges in the context of the breakdown of a close relationship, usually, although not exclusively, sexual. These stalkers pursue the person who has rejected them, to attain reconciliation, to exact revenge for the rejection or with a fluctuating mixture of both. The behaviour is usually sustained from the gratification derived either from maintaining

Box 4 A typology of stalkers

***The rejected* who pursue ex-intimates, either in the hope of reconciliation, or for vengeance, or out of a mixture of both**

***Intimacy seekers* who stalk someone they believe they love and who they think will reciprocate**

***Incompetent suitors* who inappropriately intrude on someone, usually seeking a date or brief sexual encounter**

***The resentful* who pursue victims to exact revenge for some actual or perceived injury**

***The predatory* whose stalking forms part of sexual offending**

some semblance of a relationship through the stalking or from inflicting distress.

The majority of rejected stalkers are angry, dependent males who either cannot believe they have been rejected or are unwilling to accept that rejection. Although they usually have significant limitations of personality, they only occasionally have psychotic illnesses. This is a group that can usually calculate their own advantage, and therefore the threat of judicial sanctions may be sufficient to stop the behaviour. The exceptions are those with psychoses or with issues of child access and custody, and those who believe (perhaps with reason) that this is their one and only chance for a relationship. The therapeutic focus in the rejected is often on 'falling out of love' (see Phillips & Judd, 1978) and on moving them from an angry preoccupation with the past to the sadness of accepted loss. In dependent personalities the focus is initially on the angry idealisation and on the ways in which the patient sustains a fantasy of love when all mutuality and any positive regard there may have been on the victim's part have been dissipated. The individual's capacity to abandon the investment in the lost relationship depends to a significant degree on the confidence he can muster in finding a new relationship. Critical to this is his evaluation of his social desirability and social skills. In some cases a pessimistic view of these may be well-founded, but in others it is more perception than reality. In either case establishing, or re-establishing, social contacts and social roles is critical.

The intimacy seeker

Intimacy seekers begin stalking with the aim of realising a relationship with a person who has

engaged their affections, or whom they erroneously believe already loves them. They are in love and endow their target with uniquely desirable qualities. They persist in their pursuit despite, or oblivious to, the reactions of the victim. At the onset of the stalking, intimacy seekers are almost invariably living lonely isolated lives devoid of intimacy. The fantasised relationship and the pursuit provide a pseudo-solution to their dilemma and it is this that reinforces and sustains the behaviour. For them, better unrequited love than no love, better the semblance of a relationship, however fantastic, than no prospect of intimacy. Intimacy seekers not infrequently have a major mental disorder associated with an erotomanic syndrome.

In contrast to the rejected, intimacy seekers are virtually impervious to judicial sanctions, often boasting of their 'persecution' and imprisonment as the price they are paying for true love. The only effective role for the courts in stopping this type of stalking is to ensure mandatory psychiatric treatment. The focus of management in intimacy seekers is on the underlying mental disorder and the erotomanic syndrome (see above). This should be coupled with efforts to overcome the social isolation and the lack of social competency that sustains it. Simple contributions to management should not be overlooked. A pet can sometimes soak up some of the avidity to give, and receive, affection.

The incompetent suitor

Incompetent suitors are stalkers who pursue people to whom they are attracted in a manner that evokes the targets' distress and often fear. Their targets are usually strangers or casual contacts. They are motivated not by the elevated sentiments of love, but by the desire to make contact, usually seeking a date. They evince a signal lack of basic courting skills and their approaches are inept and often intimidating. Stalkers of this type often possess a sense of entitlement to a relationship with the person who has caught their interest and show indifference to the target's preferences in the matter. The lack of social skills may derive from the stalkers' vulnerabilities of personality or occasionally from intellectual limitation. This type of stalking usually stops after a relatively brief time, presumably because there are few gratifications to sustain the behaviour. Unfortunately, stalkers in this group not infrequently move from victim to victim in a pattern of serial harassment. Although they make a significant contribution to the burden of stalking in the community because they rarely persist long enough to attract prosecution, few are referred to clinics and those that are tend to be atypical. Ending any

particular episode of stalking in this group is relatively easy – just tell them to stop it. Preventing relapse is far more problematic and often depends on persuading insensitive, overconfident males that they need to improve their social skills.

The resentful stalker

Resentful stalkers are motivated by the desire to frighten and distress their victims. Unlike most stalkers, they are well aware of the impact of their behaviour on the victim. This type of stalking emerges out of a desire for retribution against a person (or organisation) they believe has harmed or slighted them in some way. The behaviour is sustained by the satisfying sense of power and control derived from the harassment. The resentful usually feel justified in their actions and often present themselves as victims fighting back against overwhelming odds. They frequently see themselves as the 'little man' battling for justice, irrespective of a reality that is usually characterised by their merciless harassment of a vulnerable victim. The resentful are most likely to threaten but, interestingly, infrequently proceed to physical assault (Mullen *et al.*, 1999). Their aim is to frighten and intimidate, and they are usually only too aware that should they assault the victim the police will rapidly terminate their campaign. To avoid being held legally responsible, resentful stalkers often issue oblique threats (e.g. placing the victim's name in the *in memoriam* column of a newspaper or sending around the undertakers).

Diagnostically, resentful stalkers usually belong to the paranoid spectrum of disorders, with paranoid personality disorders predominating. This type of stalking sometimes emerges in individuals with querulant delusions when the progress of their claims and complaints is blocked. The workplace is the context in which many such campaigns of harassment begin, sometimes arising out of conflict between colleagues or with management, and sometimes occurring when clients target an employee or a professional who has disappointed their expectations.

Resentful stalkers tend, when first assessed, to express indignation that it is they, and not the object of their resentment, who have come before the court and have been humiliated by being sent to a psychiatrist. Few attend for treatment unless it is mandated by the court, and when they do attend, it can be difficult to move them beyond glaring silently at the therapist from a distant corner of the office. In a fortunate few there is a paranoid disorder that responds, at least partially, to antipsychotic medication. In most cases, the therapist is left struggling to engage the patient while trying to avoid becoming the next

target of complaint and resentment. As with narcissistic subjects, progress is often made by appealing to self-interest. This has to be delicately handled, as these patients often believe themselves to be animated by the pursuit of justice and convince themselves that their actions, however outrageous, are altruistic. One aspect that can be worth focusing on therapeutically is the ruminations in which the resentful relive the experiences of humiliation and injustice they attribute to the victim. These ruminations can occupy significant periods of each day and act as amplifiers of pain and anger. The focus on a distressing past and the compulsive reliving of this pain can be part of a depressive disorder or can usher in a mood disorder. We have had some success with selective serotonin reuptake inhibitors in this group. Overall, however, they are difficult patients to manage, and progress, if any, is slow in coming.

The predatory stalker

The predatory stalk preparatory to a sexual assault. The initial motivation is to gather information about the potential victim. The stalking is often extended far beyond the acquisition of information, and is sustained by the gratification derived from the voyeuristic elements, from the rehearsal, from fantasies of the planned attack and from the sense of power over the victim. The stalking is surreptitious so as not to alarm the victim, although some predatory stalkers take pleasure in raising the victim's anxiety by actions that let the target know he or she is being watched without revealing the identify or whereabouts of the stalker. Examples of such actions are entering the victim's home and moving articles around, tapping on windows at night and calling out while hidden. Fortunately, such stalkers are a rarity, at least among referrals connected primarily to stalking behaviour. However, enquiries among sex offenders reveal that episodes of stalking form part of their pattern of deviant behaviour in a remarkably wide range of cases.

Predatory stalkers should almost always be managed within a sex-offender programme, with the main focus being on the management of the paraphilia that is the driving force behind the stalking behaviour.

Managing denial and minimisation

Stalkers as a group share with sex offenders an impressive capacity to rationalise, minimise and

excuse their behaviour, however outrageous. It is essential in assessing stalkers to have access to independent accounts of the behaviour and its effects on the victims. Victim statements and victim-impact reports often exist and they should be obtained if possible. Inexperienced clinicians can easily be drawn into colluding with the sanitised and exculpatory accounts of stalkers, and on occasion can author embarrassing court reports at complete variance not only with the evidence before the court, but also with the offences for which the offender has been convicted (not infrequently following a guilty plea). It is essential to confront, not collude with, stalkers' attempts to place their own interpretations on their actions. This is true even when those interpretations derive from delusional beliefs.

Victim empathy

In addition to self-justification, stalkers often show an apparent blindness to the impact of their behaviour on the victim or, at best, offer a dismissive trivialisation. This lack of victim empathy is not, however, universal. In those stalkers motivated by a vengeful resentment there is often an acute sensitivity to the confusion, distress and fear produced by their activities. It is this very empathy that brings satisfaction and reinforces the behaviour. Similarly in those who stalk preparatory to a sexual attack, the prolongation of the behaviour beyond the needs of information gathering derives from the sensitivity to the victim's mounting discomfort and the pleasure taken in voyeuristic intrusions, with their implication of humiliating exposure. Sadism, in contrast to brutality, feeds off empathy.

Programmes developed to enhance victim empathy in sex offenders can be readily adapted for use with stalkers.

Social and interpersonal skills

It is unusual to encounter a stalker with adequate, let alone good, interpersonal and social skills. Most are drawn from the awkward, oversensitive and isolated of the world, and only the occasional individual comes from the other extreme of the overconfident and insensitive. Difficulties establishing or maintaining intimate relationships lie at the basis of many stalking episodes. Improving this area of function

can contribute not only to resolving the current stalking but also to reducing the chances of recidivism.

Many stalkers have narrowed their activities down to those involved with the pursuit. What social outlets and contacts they may once have had have been sacrificed to this preoccupation. In this context, encouraging even the most limited and banal of social activities can be helpful. We have had patients whose recovery has been aided by contacts made at establishments as varied as a golf club, evening classes and a drop-in centre. One patient responded to our encouragement to go out socially by taking up playing 'poker machines' in a local pub. This was totally successful in relieving his victim from a virtually constant harassment, which had lasted over a year, but burdened the patient with a gambling problem as he became just as focused on this new activity as he had been on the stalking.

Substance misuse

Although substance misuse is found in only a subgroup of stalkers, it must be addressed: not only does it often frustrate therapeutic interventions, it also increases the risk of progress to assault. Here as elsewhere it is all too easy to overlook the existence and the role of substance misuse. It can contribute to the background of disorganisation and rejection out of which the stalking emerges, and intoxication can cause the disinhibition and poor judgement that directly foster the behaviour.

Conclusions

Stalkers tend to evoke negative reactions. They have been demonised as a group, and health professionals are not immune to sharing popular prejudices. However, health professionals should treat stalkers not as criminals but as vulnerable, distressed people whose behaviour reflects, at least in part, the influence of mental disorder. The most important step in the management of stalkers is to accord them a legitimate status as patients. For their sake and the sake of their victims, we must continue to develop and make available relevant therapies for stalkers.

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Multiple choice questions

- The clinical management of stalkers requires:
 - treatment of any underlying mental disorder
 - understanding of the motivations that sustain the pursuit
 - mediation sessions between stalker and victim

- d enhancement of the stalker's interpersonal and social skills
 e management of any comorbid substance misuse.
2. The management of erotomanic delusions is best aided by:
 a ensuring medication compliance
 b minimising the side-effects of antipsychotics
 c enhancing the patient's poor social networks and offering alternatives to the pursuit
 d continually challenging the patient's false beliefs
 e drawing attention to the costs of continued pursuit, in terms of time, money or criminal charges.
3. The treatment of the rejected stalker should:
 a allow the patient to grieve the lost relationship
 b reduce ruminations about the idealised former relationship
 c help the patient find a new intimate partner as soon as possible
 d establish or restore social contacts or recreational pursuits
 e increase empathy for the victim.
4. An emphasis on victim empathy is ill-advised for:
 a the rejected stalker
 b the intimacy-seeking stalker
 c the incompetent stalker
 d the resentful stalker
 e the predatory stalker.
5. Stalkers frequently:
 a rationalise or minimise their intrusive behaviours
 b try to resist the impulse to stalk
 c have good social networks, which they exploit to aid their harassment of the victim
 d voluntarily seek treatment
 e have personality problems that have negative impact on their social and interpersonal functioning.

MCQ answers				
1	2	3	4	5
a T	a T	a T	a F	a T
b T	b T	b T	b F	b F
c F	c T	c F	c F	c F
d T	d F	d T	d T	d F
e T	e T	e T	e T	e T