

The Problem Behavior Model: The Development of a Stalkers Clinic and a Threateners Clinic

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Traditionally, forensic mental health services have focused on the assessment and treatment of offenders with serious mental disorders. In recent years, there has been growing recognition that forensic clinicians have an important role to play for those offenders who engage in criminal acts driven by psychological and/or social problems, which may, or may not, occur in conjunction with a major mental disorder. This is especially true for specific offenses such as stalking and threatening. This article describes the innovation of the problem behavior model. This model uses a reductionist approach and the nexus between psychiatry and psychology to address the complex phenomena associated with specific problem behaviors that often culminate in offenses. The model is illustrated by describing the development of specialist clinics for the problem behaviors of stalking and threatening. Copyright © 2005 John Wiley & Sons, Ltd.

The courts have long called upon mental health clinicians to illuminate the mental element in criminal behavior, and demand for such services continues to grow (Cohen, 1997; Melton, Petrila, Poythress, & Slobogin, 1997; Otto & Heilbrun, 2002). Traditionally, the tendency is to focus on the impact on offending of the active symptoms of mental disorder, such as delusions, hallucinations, and mood disorders. This is particularly so in consideration of the so-called mental state defenses, where the law gives priority to disturbances of reasoning and perception. Less obvious is the need

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for such a focus when providing reports directed to issues of sentence and future management, which in Australia constitute the vast bulk of reports to criminal courts. There, the priority is formulating potential management strategies for those elements in the social and psychological as well as psychopathological make-up of an individual that have contributed to the offending and that are likely to increase the risk of re-offending (Bonta, Law, & Hanson, 1998; Hodgins, 1992).

Clinicians have always hoped to approach the assessment and management of mentally disordered offenders in a manner that gives due weight not just to issues of managing active symptoms, but also to those vulnerabilities of personality, damaging behaviors, and social context that contribute to the emergence, and persistence of offending. In practice, however, there has been an increasing divorce between approaches to the management of the mentally disordered offender and those approaches employed with programs to reduce recidivism in the general offender population. On one hand, the symptoms of the mental disorder have a priority that overshadows or even obscures the criminogenic influences present in the individual's social, psychological, and behavioral realities. On the other hand, a focus on changing behavior may overlook or ignore the psychopathological and social contributions to recidivism. On one hand, offenders have very high levels of psychopathology. On the other, mentally disordered offenders share many of the developmental, social, and psychological burdens of the general offender populations. Though we believe there is continuing value in separating the populations, ideally there should be greater cross-fertilization in ideas and approaches to decreasing recidivism. The management of sex offenders, particularly child molesters, offers a model for such a coming together. Mental health professionals have brought their approaches to the struggle to reduce a particularly distressing group of problem behaviors and, in the process, have moved from a narrow focus on psychopathology to a wider perspective on the roots of offending. The assessment and management of sexual offenders, although still constrained by the tendency to diagnose paraphilias in cases of aberrant sexuality, has been increasingly informed by the notion of descriptive models and behaviorally based typologies (see, e.g., Groth & Birnbaum, 1979; Groth, Burgess, & Holmstrom, 1977; Prentky & Knight, 1991). The major advantages of these models are the strong relationship between the model and the data on which they are built and the inclusion of all those exhibiting the offending behavior, irrespective of which, if any, diagnostic label they attract (Farrington Hollin, & McMurrin, 2001; Marshall, Anderson, & Fernandez, 1999).

Drawing on the research emphasizing the importance of expanding the scope of forensic mental health services beyond a predominant focus on active symptoms of mental disorder, we discuss the development of a problem behavior model.

THE PROBLEM BEHAVIOR MODEL

Problem behaviors encompass actions that can intentionally or recklessly cause harm to others. Harm includes not only physical injury and property damage, but damage to the psychological and social well being of victims. Examples of problem behaviors are stalking, firesetting, and uttering threats. It is worth noting that the perpetrator can also come to grief socially, psychologically, and legally as a result of such behavior.

Many societies today are becoming increasingly intolerant of all forms of violence and intimidation. This is reflected in the development and refinement of criminal law, such as sexual harassment and stalking laws during the 1990s. It is also evidenced in the increasing number of legal actions arising from behaviors such as sexual harassment and workplace intimidation, which had been previously ignored, if not covertly condoned (see, e.g., Department of Justice, 1988–2002). This has been accompanied by an escalating rate of referrals of those convicted of such crimes to forensic mental health services.

Initial consideration might suggest that problem behaviors encompass the gamut of criminal conduct and the term itself is interchangeable with the term “criminal behavior.” The reason why the term “problem behavior” is useful is because it includes all incidents, not only those prosecuted, and it can promote the idea of clinical specialization in certain types of conduct rather than narrowly focusing on certain types of disorder. The problem behaviors of particular interest to mental health professionals are those in which perpetrators are known to have high levels both of frank mental illness and significant personality problems. Stalking, arson, and the issuing of threats are prime examples (Barnes, Gordon, & Hudson 2001; Doley, 2003; Mullen, Pathé, & Purcell, 2000). The objective of promoting a problem behavior category is not to pathologize certain criminal activities, but to give recognition to the need to approach certain offenders with a model that can do justice to the factors in their psychological and social functioning that are criminogenic. It attempts to avoid conflating the criminal behavior with the symptoms of a mental disorder. We doubt the value of creating new mental disorders to designate certain subgroups of offenders by appeal to putative disorders, be they of an obsessional, impulse control, anxiety reducing, appetite, or paraphillic type. We believe that turning socially and personally damaging behaviors into specific mental disorders will be less heuristically and practically useful than addressing the psychological and social determinants of those problem behaviors.

The problem behavior approach does not abandon traditional knowledge and interventions, but builds on them by incorporating wider aspects of current knowledge. This can include studies in abnormal psychology, social learning theories of aberrant behavior, and risks of recidivism in clinical and nonclinical samples. Research has long advocated the need for empirically derived treatment programs for offenders driven by those with sound knowledge of the problem behaviors they seek to treat (deBecker, 1997; MacDonald, 1968; Meloy, 1998; Mullen, Pathé, Purcell, & Stuart, 1999; Ogloff, Wong, & Greenwood, 1990).

The problem behavior model favors a reductionist approach in so far as it examines the individual components of complex problem behaviors to enhance our understanding and treatment, while also accepting that such behaviors cannot be isolated from the context in which they occur. As a rule, forensic mental health services have accepted only those people thought to have a mental illness or serious personality disorder, thus excluding all those people not fitting into these traditional categories. This practice not only underestimates and undervalues the expertise of forensic mental health clinicians, but also excludes offenders with difficult and problematic behaviors who can potentially benefit from this expertise.

It is our contention that mental health professionals have a responsibility to see their patients as more than merely embodiments of symptoms of currently recognized mental disorders. As such, the development of knowledge in specific problem

behaviors, often culminating in specific offenses, provides a broader view of the patient and a more recognizable referral point for criminal justice and mainstream health services. Furthermore, it facilitates a return to the fundamental concerns of clinicians caring for individuals suffering within their social and cultural contexts. Importantly, this approach is also a springboard to research studies producing findings that can inform colleagues, the judiciary, policy makers, and the public about those who engage in problem behaviors.

The development of two specialist clinics within a statewide forensic mental health service illustrates the practical application of the problem behavior model.

THE DEVELOPMENT OF A STALKERS' CLINIC AND A THREATENERS' CLINIC

The Stalkers' Clinic was developed from ongoing research interest in the area and an emerging demand from the courts for advice on the new area of criminal offending (Mullen *et al.*, 2000). Research suggests that 12.8% of males and 32.4% of females experience being stalked sometime during their life, with 10% reporting a protracted course of such harassment lasting months or years (Purcell, Pathé, & Mullen, 2002).

The Stalkers' Clinic¹ is based in the outpatient clinic of a statewide forensic mental health service and provides expert opinions to courts, community corrections, regional mental health services, and, to a lesser extent, private clinicians. In addition to the assessment service provided, stalkers deemed suitable are accepted for treatment in cases where existing services cannot address their needs. The clinic provides reports to courts following conviction and to defense attorneys where a guilty plea has been entered. This reduces the chance of being drawn into attempting to assess individuals who are either denying the behavior, or looking for some form of mental state defense. Frequently, those convicted and referred for pre-sentence reports initially deny their offenses. Usually, denials have less to do with the behavioral elements of the offense and are more about the criminal intent, or just refusing the label of "stalker". This group may respond to gentle confrontation about the reality of their actions and the known consequences for the victim, or simply accept that though they feel unjustly treated they have to learn to modify their future behavior. Those who continue to deny they acted in the manner that led to their conviction are, unless the denial arises from serious mental illness, returned to the court with a report noting the inability to assess the origins of the behavior or to make recommendations. This is done only with great reluctance, and only after explaining to the client, and the attorney if necessary, the potential complications of returning to court with a report that could be interpreted as denying offenses of which the client has already been found guilty.

¹An issue of note in the development of the Stalkers' Clinic is its name. This label initially attracted criticism and sardonic rhetoric, not only from incensed offenders but also police prosecutors and other members of the judiciary. This initial criticism was weathered as it was considered that acknowledging the precise nature of the stalking behavior was the first step in its management. As time has progressed, the name has proven to be a beacon for legal and health professionals previously at a loss to know where to obtain advice and support in regard to this complex behavior.

The clinic melds psychiatric and psychological assessment to elicit the broad scope of information required to comprehensively assess the offender's mental functioning, social influences, and risks of recidivism. An additional advantage is the chance to discuss each assessment, this enabling further clarification of any ambiguities and nuances of the case. The expertise of other mental health disciplines, such as social work, are called upon in the case of the socially dislocated offender, or if the offender's ongoing relationship with a partner is playing a significant role.

Paralleling the development of the Stalkers' Clinic was the development in late 2001 of the Threateners' Clinic. Threats to kill or otherwise harm another person are seen in an increasing number of referrals to the outpatient clinic of the statewide forensic mental health service. For example, one person referred for psychological treatment issued threats to kill and bomb threats to police up to 30 times per day. While a number of threats issued by those referred for assessment had been issued in the context of stalking, many had not. Research indicates that more than 50% of stalkers threaten to kill or otherwise harm their victim (Harmon, Rosner, & Owens, 1998; Meloy, 1998; Mullen et al., 1999). Threats also arose from interpersonal conflicts such as domestic or workplace disputes, and in the provision of professional services such as caring for the mentally disordered.

Research from the Threateners' Clinic is being prepared from collected assessment data. This research is seen as highly pertinent to mental health clinicians because scientific literature has yet to explore many of the empirical questions about threats. For example, the weight of threats is often based on common sense and the assessing clinician's experience (Mullen, 1997). Overall, threats are more often uttered than acted upon (Borum, Fein, Vossekuil, & Bergland, 1999; Fein, Vossekuil, & Holden, 1995).

The definitions of these problem behaviors shaped the development of the clinics and was grounded in both scientific discourse and legislation. Stalking has been defined as repeated, unwanted communications and/or intrusions that are inflicted by one individual on another, producing fear in the victim (Mullen et al., 2000). The definition of a threat is more long-winded as threats can have a range of manifestations. The uttering of a threat is a communication (Milburn & Watman, 1981). Threats can be delivered verbally, in writing, or as a gesture (such as a hand drawn across the throat). Threats can also be implied, as in the case of the Threateners' Clinic client whose victim read their death notice in the local newspaper. While the content of threats varies from threats to kill to threats of physical or psychological harm, to property damage or even reputational damage, the common theme is that they are harbingers of harm that cause the recipient fear. A threat can be uttered directly to the victim or via a third party such as a family member, acquaintance, or colleague. In Victoria, Australia, stalking and threat offenses appear in the Crimes Act 1958 under the sections described in Table 1.

THE ASSESSMENT PROCESS

The assessment processes in the Threateners' Clinic and the Stalkers' Clinic are similar. Each assessment lasts between 3 and 6 hours and is conducted by a Forensic Psychiatrist and a Clinical-Forensic Psychologist. Typically, the clinics conduct four or five assessments per week and the flow of referrals has been consistent. The

Table 1. Stalking and threat offenses in the Victorian Crimes Act 1958

Crimes Act section	Offense
20	Threat to kill
21	Threat to inflict serious injury
21A	Stalking
27	Extortion with threat to kill
28	Extortion with threat to destroy property
30	Threatening injury to prevent arrest
57	Procuring sexual penetration by threats or fraud
198	Threats to destroy or damage property
246E	Threats to safety of aircraft
250	Threatening to contaminate goods with intent to cause public alarm or economic loss
317A	Bomb hoax

assessment process consists of a semi-structured clinical interview and the administration of a standardized battery of psychological tests. Perhaps surprisingly, very few stalkers or threateners have refused to complete the assessment on the basis of its length. This may be in part due to the extended opportunity to share their side of their stories or the comprehensive verbal feedback offered.

At the onset, the limitations on confidentiality are explained to the patient. Anything revealed can be used in the assessment and conveyed to the court, or referring agencies. They are clearly told that they are at liberty to decline to answer any specific questions they find too intrusive or refuse to provide information on particularly sensitive areas. If such refusals are likely to seriously disrupt the assessment, they will be told at the time and the issue and implications discussed to enable them to make an informed decision. In those with serious mental disorders, where their capacity to calculate their own advantage and protect themselves may be impaired, the assessors can act in the patients' best interests. In practice, with the seriously mentally disordered, the reports focus on the history and mental state specifically relevant to the offense and the disorder, and eschew any details that could subsequently embarrass or damage the patient. Our ethical stance is that of mental health professionals who act to the benefit of our patients. We believe resorting to explanations of offenses in terms of disordered mental states and disrupted psychological functioning (and making treatment recommendations on the basis of such assessments) is beneficial only if the individuals will benefit significantly from therapy, but potentially harmful if they are not. Therefore, no ethical dilemma is created by not making a treatment recommendation. Our reports, at worst, are aimed to present the offender as a person within a social, personal, and psychological context. It is not our role to act as interrogators revealing previously undisclosed offenses, or to bring to the court's attention potentially prejudicial aspects of the patient's past.

We approach assessment as health professionals and potential future therapists, not as abstracted truth tellers, or ersatz members of the court or legal fraternity. This is a stance hallowed by history and practice in Australia, whose legal system remains closely allied to that of the UK. We recognize that a different history and different imperatives are operative in the U.S.

In the interview, clients are asked structured questions about their childhood, adolescence, and adult lives, their educational and work histories, relationship and

sexual histories, and their current situations. Assessment of mental and physical health histories includes details of any past assessments and management attempts. If it is feasible, collaborative information is requested from relatives or significant others. Offense histories are sought from the offender and from official records wherever possible. Victim impact statements are always requested when the referral comes from the judicial system. While direct contact with a victim is inadvisable for a myriad of reasons, informing the authorities working with the victim of available support services is seen as important (Mullen et al., 2000).

In cases of stalking and threatening, consideration of the motive behind the behavior constitutes a critical part of the assessment. In stalking cases the literature (Meloy, 1998; Mullen et al., 1999) has identified a number of motivations, which include

- (i) a desire to establish a relationship, which may or may not be sexual,
- (ii) the desire to re-establish a close relationship,
- (iii) exacting revenge or vindication for a perceived insult or injury, or
- (iv) the pursuit of a victim to gather information or gain control prior to an assault, usually sexual in nature.

These motives may not be mutually exclusive and can change over time. For example, a stalker initially driven by a desire to reconcile with an ex-partner may become increasingly angry and vindictive when repeated approaches are rebuffed.

The research literature has suggested a number of motivations for uttering threats, which includes expressing emotion (Fein & Vossekuil, 1999; Fein et al., 1995; Milburn, 1977), intimidation (Felson & Tedeschi, 1993), an appeal for help (Fein & Vossekuil, 1999; MacDonald, 1968), an attempt to control another's behavior such as attempting to restrain their freedom of action (Felson & Tedeschi, 1993; Hough, 1990; Milburn & Watman, 1981; Newhill, 1992); warning (Fein & Vossekuil, 1999), and as a response to danger (Milburn, 1977). Mentally disordered patients can also use threats and violence for many reasons including managing conflict in their lives (Lanza, 1996) and threats issued to enhance the chance of a psychiatric hospital admission (MacDonald, 1968).

All assessments include an evaluation of both the presence of psychopathology and its impact on the problem behavior. Consistent with studies of other offenses, a range of mental disorders have been identified among stalkers. Some of the most common are delusional disorders, schizophrenia, bipolar affective disorders, major depression, substance abuse, and personality disorders (Kienlan, Birmingham, Solberg, O'Regan, & Meloy, 1997; Meloy & Gothard, 1995; Mullen et al., 1999; Roberts, 2002; Schwartz-Watts & Morgan, 1998; Zona, Sharma, & Lane, 1993). Paraphilias have also been identified in stalkers who have committed or planned sexual assaults (Mullen et al., 1999). Diagnosable personality disorders are also frequent and usually of the dependent, inadequate and narcissistic types (Harmon et al., 1998; Meloy & Gothard, 1995; Meloy, Rivers, Siegel, Gothard, Naimark, & Nicolini, 2000; Mullen et al., 1999; Zona, Palarea, & Lane, 1998).

There is a modest literature that empirically examines threats (Calhoun, 1998; Dietz et al., 1991a, 1991b; Meloy, 2001; Scalora, Baumgartner, & Plank, 2003). One of the few systematic studies of psychiatric assessment after uttering a homicidal threat reported nearly half to be psychotic and most of the rest personality disordered (MacDonald, 1968). A more recent study found over half to have some

form of mental disorder and some 70% to have significant personality problems (Barnes *et al.*, 2001).

Assessments conducted in the Stalkers' and Threateners' Clinics include the administration of a standardized battery of psychological tests, which includes the Minnesota Multiphasic Personality Inventory—Second Edition (Hathaway & McKinley, 1989), the Wechsler Abbreviated Scale of Intelligence (Psychological Corporation, 1999), the State–Trait Anger Scale, Second Edition (Spielberger, 1999), the Interpersonal Reactivity Index (Davis, 1983), Attachment Style (Bartholomew & Horowitz, 1991), Locus of Behavioral Control (Craig, Franklin, & Andrews, 1984), the Composite International Diagnostic Interview, Drug and Alcohol module (World Health Organisation, 1997), and the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997); which incorporates the Hare Psychology Checklist—Revised (Hare, 2003).

Written opinions are provided to referrers based on the assessment results and the background information provided. These reports are authored by the Forensic Psychiatrist and Clinical–Forensic Psychologist and include information on current psychopathology, the nature and possible motivations of the problem behavior(s), risk for violence, and recommendations regarding management and treatment.

TREATMENT

The limits on confidentiality are spelled out at the onset of therapy and are reiterated regularly through the progress of treatment. It is explained to the patients that their interests are paramount. Actions on their part that are likely to result in damage to others we will, however, regard as seriously detrimental to them, as well as to the potential victims, and take whatever action we feel will best reduce the risk of such behavior. We explain that this could involve informing potential victims or the police to remove weapons, for example. In practice, we have involved the police in seizing guns from patients and intervening to suspend a father's access to his children where an imminent risk of violence existed. Interestingly, such actions, far from disrupting the therapeutic alliance, have tended to be beneficial. To date, we have successfully resisted attempts by the police and crown prosecution services to gain access to patients' notes to further their investigations. The courts have recognized a public interest immunity based on the need for confidentiality in treating potential offenders.

Treatment services for these groups are in development. Individual treatment is provided to those clients assessed as both suitable and in need of specialist forensic mental health treatment. Clinical management of any contributory mental disorder is central and includes consideration of medication and psychological treatment. Substance abuse often has to be specifically addressed. A functional analysis model is then used to ascertain the motivations and needs that both initiate and sustain the problem behavior. Cognitive–behavioral techniques are employed to challenge the cognitions that sustain the problem behaviors. While treatment is tailored for each client, frequently used strategies include examinations of cognitive distortions and self-deceptions that serve to deny, minimize, or justify the behavior. Where possible, client deficits are also addressed, such as limited victim empathy, inappropriate social and interpersonal skills (Mullen, Pathé, & Purcell, 2001), and poor expressive and receptive communication skills.

EVALUATION AND RESEARCH INITIATIVES

The Stalkers' and Threateners' Clinics offer a unique opportunity to further the available knowledge of the characteristics, problems, and effective treatment strategies for this population. The Stalkers' Clinic is currently the subject of a psychology doctoral research study that is exploring the psychological characteristics of subtypes of stalker based on a typology proposed by Mullen and colleagues (Mullen et al., 2000). The Threateners' Clinic data is included in a doctoral thesis being prepared exploring the epidemiological and phenomenological characteristics of uttering threats to harm others.

FUTURE DIRECTIONS

The problem behavior model lends itself to the development of expertise in numerous areas. Recently, the Stalkers' and Threateners' Clinics have amalgamated into the newly formed "Problem Behavior Clinic." Other specialities currently being developed there include persistent firesetting and problem gambling that results in criminal prosecution. The aim of a specialist clinic based on the problem behavior model is to establish a center of clinical expertise and research opportunity providing support and education for clinicians, legal and criminal justice staff, the general public, and, of course, the patient.

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